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ABSTRACT

This document contains the texts of two Congressional hearings examining youth suicide, youth suicide prevention, and the appropriate role of the federal government. The texts of two bills are included: H.R. 1099 which would require the Secretary of Education to establish a grant program to assist local educational agencies in operating school-based teenage suicide prevention programs; and H.R. 1894, which would establish a commission for the study of youth suicide and a program of grants for suicide prevention programs within the Department of Health and Human Services. Congressmen Ackerman and Lantos presented these bills and they discuss the problem of youth suicide. Statements by Congressmen Hawkins and DioGuardi are given. Witnesses from the first hearing include Charlotte Ross, president, Youth Suicide National Center; Debra Meckley, National Association of Social Workers; Fred Wyatt, student; and John Carswell, Child Welfare League of America. The text of the second hearing contains statements by Congressman Biaggi, Ackerman, and DioGuardi, and testimonies from: (1) Alfred DelBello, chairman, National Community of Youth Suicide Prevention; (2) Stephen J. Friedman, deputy commissioner, Westchester County Department of Community Mental Health; (3) George Cohen, American Association for Counseling Development; (4) Beth Corney, peer leader, White Plains School District; (5) Ann Kliman, Center for Preventive Psychiatry; (6) Ethel Rosally, Yonkers Board of Education; and (7) Louise Latty, New York City Board of Education. Prepared statements and other materials submitted for the record are included. (NB)

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HEARINGS ON YOUTH SUICIDE PREVENTION ACT OF 1985

HEARINGS

BEFORE THE

SUBCOMMITTEE ON ELEMENTARY, SECONDARY, AND VOCATIONAL EDUCATION

OF THE

COMMITTEE ON EDUCATION AND LABOR
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

FIRST SESSION

ON

H.R. 1099 and H.R. 1894

TO MAKE GRANTS AVAILABLE FOR TEENAGE SUICIDE PREVENTION PROGRAMS

HEARINGS HELD IN WASHINGTON, DC, SEPTEMBER 10, 1985, AND YONKERS, NY, OCTOBER 21, 1985

Serial No. 99-56

Printed for the use of the Committee on Education and Labor

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HEARINGS ON YOUTH SUICIDE PREVENTION ACT OF 1985

MONDAY, SEPTEMBER 10, 1985

House of Representatives,
Subcommittee on Elementary, Secondary, and
Vocational Education,
Committee on Education and Labor,
Washington, DC.

The subcommittee met, pursuant to call, at 9:40 a.m., in room 2175, Rayburn House Office Building, Hon. Augustus F. Hawkins (chairman of the subcommittee) presiding.

Members present: Representatives Hawkins, Kildee, Martinez, Fawell, and Gunderson.

Staff present: John F. Jennings, counsel; Nancy Kober, legislative specialist; and Andrew Hartman, Republican legislative associate.

Also present: Representative Ackerman.

[Text of H.R. 1099 and H.R. 1894 follow:]

I

99th CONGRESS
1st Session

H. R. 1099

To make grants available for teenage suicide prevention programs.

IN THE HOUSE OF REPRESENTATIVES

February 19, 1985

Mr. **Ackerman** (for himself, Mr. **Hawkins**, Mr. **Miller** of California, and Mr. **Biaggi**) introduced the following bill; which was referred to the Committee on Education and Labor

---

A BILL

To make grants available for teenage suicide prevention programs.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) The Secretary of Education shall establish a grant program to assist local educational agencies to establish and operate programs of teenage suicide prevention in accordance with this Act.

(b)(1) Any local educational agency which desires to receive a grant from the Secretary under this Act shall submit an application to the Secretary in such form and at such times as the Secretary may require.

(2) Such application shall provide assurances that Federal funds made available under this Act will be so used as to supplement and, to the extent practicable, increase the amount of State and local funds that would in the absence of such Federal funds be made available for the uses specified in this Act, and in no case supplant such State or local funds.

(c) Any program established and operated by a local educational agency under this Act shall—

(1) assist in increasing the awareness, among school personnel and community leaders, of the incidence of teenage suicide;

(2) train school personnel in individual and school-wide strategies for teenage suicide prevention;

(3) develop and implement school-based teenage suicide prevention programs and pilot projects; and

(4) through cooperative efforts, utilize community resources in the development and implementation of teenage suicide prevention programs under this Act.

(d) Any grant made by the Secretary under this Act shall not exceed $100,000 in any fiscal year.

(e) There is authorized to be appropriated $10,000,000 in each of the fiscal years 1986, 1987, and 1988 to carry out this Act.

(f) For purposes of this Act—

(1) the term "local educational agency" has the meaning given in section 1001(f) of the Elementary and Secondary Education Act of 1965; and

(2) the term "Secretary" means the Secretary of Education.

○

99TH CONGRESS
1ST SESSION

H. R. 1894

To establish a commission to conduct a study of the problems of youth suicide in the United States for the purpose of providing guidance in developing national policy, and to establish a grant program for States, political subdivisions of States, and private nonprofit agencies for programs to prevent suicide among children and youth.

IN THE HOUSE OF REPRESENTATIVES

APRIL 2, 1985

Mr. **LANTOS** (for himself, Ms. **SNOWE**, Mr. **BENNETT**, Mr. **BERMAN**, Mr. **BIAGGI**, Mr. **BONIOR** of Michigan, Mr. **BORSKI**, Mr. **BUSTAMANTE**, Mr. **COELHO**, Mr. **DIOGUARDI**, Mr. **DYMALLY**, Mr. **EDWARDS** of Oklahoma, Mr. **FAUNTROY**, Mr. **FORD** of Tennessee, Mr. **KOLTER**, Mr. **LELAND**, Mr. **MANTON**, Mr. **MARTINEZ**, Mr. **MITCHELL**, Mr. **MRAZEK**, Mr. **OWENS**, Mr. **REID**, Mr. **ROSE**, Mr. **SILJANDER**, Mr. **SUNIA**, Mr. **TOWNS**, Mr. **WEISS**, and Mr. **YOUNG** of Alaska) introduced the following bill; which was referred jointly to the Committees on Energy and Commerce and Education and Labor

---

A BILL

To establish a commission to conduct a study of the problems of youth suicide in the United States for the purpose of providing guidance in developing national policy, and to establish a grant program for States, political subdivisions of States, and private nonprofit agencies for programs to prevent suicide among children and youth.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Youth Suicide Prevention Act of 1985".

SEC. 2. FINDINGS.

The Congress finds that—

(1) suicide is a significant national health problem affecting young people, as demonstrated by the following facts:

(A) suicide is currently the eighth leading cause of death in the United States, the third leading cause of death among adolescents, and the second leading cause of death among college and university students; and

(B) the rate of suicide in this country during the last twenty-five years among individuals fifteen to twenty-four years of age has increased threefold;

(2) research and national statistics on the physical, psychological, and social conditions associated with suicide have not been coordinated or integrated to provide an adequate data base for dealing with this serious national health problem;

(3) additional research and demonstration treatment models, emphasizing multidisciplinary approaches, are needed to provide the most successful and cost effective solutions to this problem;

(4) primary prevention of youth suicide must begin before self-destructive behavior reaches advanced stages, which often requires medical treatment and resources of governments on the Federal, State, and local levels;

(5) primary prevention programs that are aimed at providing community education activities to the general public are the most effective means of reaching children and youth before self-destructive behavior reaches advanced stages and thus are the best means of reducing youth suicide;

(6) suicide problems exist at times in combination with other self-destructive behavior, such as drugs and alcohol;

(7) suicide prevention programs for children and youth should emphasize cooperation involving educational and health programs at the State and local levels with local community resources, including private nonprofit agencies; and

(8) existing funds for prevention of suicide among children and youth is inadequate at all government levels.

TITLE I—COMMISSION FOR THE STUDY OF YOUTH SUICIDE

SEC. 101. PURPOSE.

It is the purpose of this title to establish a commission (A) to conduct a study which will address the causes of suicide among children and youth and identify the most promising crisis intervention strategies, and (B) to develop a short- and long-range national plan to assist States and communities in implementing effective youth suicide programs.

SEC. 102. ESTABLISHMENT OF COMMISSION FOR THE STUDY OF YOUTH SUICIDE.

There is hereby established a commission to be known as the Commission for the Study of Youth Suicide (in this title referred to as the "Commission").

SEC. 103. DUTIES OF THE COMMISSION.

(a) STUDY AND NATIONAL PLAN.—The Commission shall—

(1) conduct a study that will (A) examine the causes of suicide among children and youth (B) identify the most promising strategies for intervening in and preventing suicide, and (C) analyze the options available for assisting States and communities in implementing youth suicide prevention programs; and

(2) prepare both a short- and long-range national plan for the prevention of youth suicide.

(b) **Report.**—The Commission shall transmit to the President and to each House of the Congress a report not later than fifteen months after the date on which the Commission holds its initial meeting. The report shall contain a detailed statement of the findings, conclusions, and recommendations of the study.

SEC. 104. MEMBERSHIP.

(a) **Members.**—The Commission shall be composed of thirteen members as follows:

(1) the Secretary of Health and Human Services (in this title referred to as the "Secretary") or his or her delegate;

(2) the Secretary of Education or his or her delegate;

(3) two members appointed by the Secretary from a list of at least five individuals submitted by the American Association of Suicidology;

(4) two members appointed by the Secretary from a list of at least five individuals submitted by the American Medical Association;

(5) two members appointed by the Secretary from a list of at least five individuals submitted by the American Psychological Association;

(6) two members appointed by the Secretary from a list of at least five individuals submitted by the American Psychiatric Association, and

(7) three members appointed by the Secretary from among citizen leaders to represent the public.

(b) Travel Expenses.—Members of the Commission shall serve without pay, but shall receive per diem and travel expenses in accordance with section 5703 of title 5, United States Code, for each day during which they are engaged in the actual performance of duties vested in the Commission.

(c) Chairperson.—The Chairperson of the Commission shall be elected by the members of the Commission.

(d) Meetings.—The Commission shall meet at the call of the Chairperson or a majority of its members.

(e) Term.—The term of the members shall be for the life of the Commission. A vacancy in the Commission shall not affect its powers and shall be filled in the manner in which the original appointment was made.

SEC. 105. DIRECTOR AND STAFF OF COMMISSION.

(a) Director.—The Commission shall have a Director who shall be appointed by the Chairperson and who shall be paid at a rate not to exceed the maximum rate of basic pay payable for GS-18 of the General Schedule.

(b) Staff.—The Director may appoint additional staff members to the extent authorized by the Commission.

(c) **Detailed Staff.**—Upon request of the Commission, the head of any Federal agency is authorized to detail, on a reimbursable basis, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties under this Act.

SEC. 106. POWERS OF COMMISSION.

(a) **Hearings.**—The Commission or any member it authorizes may, for the purpose of carrying out this title, hold such hearings, sit and act at such times and places, request such attendance, take such testimony, and receive such evidence, as the Commission considers appropriate.

(b) **Obtaining Official Data.**—The Commission may obtain from any department or agency of the United States information necessary to enable it to carry out this Act. On the request of the Chairperson of the Commission, the head of such department or agency shall furnish such information to the Commission.

(c) **Task Forces.**—The Commission, in order to provide a broader spectrum of specialized knowledge, may involve other individuals in its activities through the creation of task forces to deal with issues of research, education, facilities and treatment, and public policy.

(d) **Mails.**—The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the United States.

(e) GIFTS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

(f) ADMINISTRATIVE SUPPORT SERVICES.—The Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

(g) PERSONNEL.—The Commission may appoint and fix the pay of such personnel as it considers appropriate. Such personnel may be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and may be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title, relating to classification and General Schedule pay rates. No individual so appointed may receive pay in excess of the maximum annual rate of pay payable for GS–18 of the General Schedule under section 5332 of title 5, United States Code.

SEC. 107. TERMINATION.

The Commission shall cease to exist at the end of the ninetieth day following the date on which the report described in section 103 is transmitted.

SEC. 108. AUTHORIZATION.

There is authorized to be appropriated to carry out this title an amount not to exceed $1,500,000 for each of fiscal years 1986 and 1987.

TITLE II—GRANTS FOR PROGRAMS TO PREVENT SUICIDE AMONG CHILDREN AND YOUTH

SEC. 201. PURPOSE.

It is the purpose of this title to establish a grant program to aid States, political subdivisions of States, and private nonprofit agencies to carry out programs for the prevention of suicide among children and youth.

SEC. 202. GRANTS.

(a) ELIGIBLE PROGRAMS.—From amounts appropriated under section 206 for any fiscal year, the Secretary of Health and Human Services (in this title referred to as the "Secretary"), in cooperation with the Secretary of Education, shall make a grant to each applicant whose application is approved under section 203 for the purpose of establishing and operating projects to prevent youth suicide. Such projects may include—

(1) youth school programs;

(2) training of personnel (such as teachers, counselors, and detention center workers) on the signs of self-destructive behavior;

(3) establishment of community resources (such as twenty-four hour "teen hot-lines");

(4) production, design, and distribution of community educational materials, including public service announcements for television and radio;

(5) production of printed materials; and

(6) national and international conferences on youth suicide prevention.

(b) REGULATIONS.—The grants shall be made under such terms and conditions as the Secretary, in cooperation with the Secretary of Education, shall prescribe by regulation.

(c) AMOUNT.—The Secretary may award to one applicant not more than a total of $500,000 for fiscal years 1986, 1987, and 1988. In no event shall the amount of a grant to an applicant for a fiscal year exceed 50 per centum of the estimated cost of the projects for which the grant is made for such fiscal year as determined by the applicant.

SEC. 203. APPLICATIONS.

(a) ELIGIBILITY.—A State, a political subdivision of a State, or a private nonprofit agency may apply for a grant under section 202. Each such State, political subdivision of a State, or private nonprofit agency that desires to receive a grant for a fiscal year under section 202 shall submit an application to the Secretary. The Secretary shall approve an application if the applicant qualifies under subsection (b) and meets such other requirements that the Secretary may by regulation prescribe. The application shall contain such information and assurances as the Secretary considers necessary.

(b) Qualifications.—To qualify for a grant for any fiscal year under this Act—

(1) an applicant that is a State or a political subdivision of a State shall have in effect and be implementing a primary suicide prevention program directed at children and youth; and

(2) an applicant that is a private nonprofit agency shall demonstrate, in a manner prescribed by regulation by the Secretary, that the agency is cooperating with other private agencies and with governments at the local, State, and Federal level to help prevent suicide among children and youth.

SEC. 204. ADMINISTRATIVE PROVISIONS.

(a) Annual Report.—The Secretary, in consultation with the Secretary of Education, shall transmit to the President and to both Houses of Congress an annual report evaluating the types and effectiveness of programs and activities assisted under this Act during the preceding fiscal year. The last report transmitted under this section shall contain recommendations on the desirability of continuing such grants.

(b) Audit.—The Comptroller General of the United States shall have access for the purpose of audit and examination to any books, documents, papers, and records of any State, political subdivision of a State, or private nonprofit agency receiving assistance under this Act that are pertinent to the sums received and disbursed under this Act.

SEC. 205. TERMINATION.

The grant program established by this title shall terminate three years after the first grant is awarded.

SEC. 206. AUTHORIZATION.

There is authorized to be appropriated to the Secretary for grants under this title an amount not to exceed $6,000,000 for each of fiscal years 1986, 1987, and 1988.

○

Chairman **Hawkins**. The Subcommittee on Elementary, Secondary, and Vocational Education is called to order.

This morning the subcommittee will be examining the alarming problem of youth suicide. Since 1960, suicide rates among the age group of 15 to 24 have tripled. This year, 6,000 young people are likely to commit suicide.

Those of us who devote our energies to helping make sure that children are educated, fed, and cared for cannot overlook a problem that robs our young people of their most precious gift. The loss of a young life deeply affects not only the family, friends, and community of the young victim; it ultimately affects our larger society, because we will never know or benefit from that child's potential.

At this hearing, I hope we can review what we can do about youth suicide and how to prevent it, as well as discuss an appropriate leadership role for the Federal Government.

Two bills are pending before the subcommittee which address this problem. H.R. 1099, introduced by Congressman Ackerman, would require the Secretary of Education to establish a grant program to assist local educational agencies in operating school-based teenage suicide prevention programs. H.R. 1894, introduced by Congressman Lantos, would establish a commission for the study of youth suicide and would establish a program of grants for suicide prevention programs within the Department of Health and Human Services.

I wish to commend both Congressman Lantos and Congressman Ackerman for taking the initiative on this serious issue. We welcome both of you here this morning as our first witnesses.

The subcommittee, I would like to inform you, intends to continue an examination of this issue at another hearing in New York later this year.

It is my understanding that Mr. Lantos, our distinguished colleague, has a time problem and we will call on him first; also, recognizing that Mr. Ackerman, who was at one time a member of this committee, will be heard from following Mr. Lantos. We certainly welcome both of you to the hearing this morning. We look forward to your testimony.

Mr. Lantos.

STATEMENT OF HON. TOM LANTOS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. **Lantos**. Thank you very much, Mr. Chairman.

First, I want to express my personal appreciation to the members of your committee for taking up this subject which I consider to be a national nightmare. Before dealing with the specifics of my legislation I want to pay public tribute to my good friend and colleague, Congressman Ackerman, for taking national leadership on this issue. I also want to recognize Ms. Charlotte Ross, who is a constituent of mine, and who, in my own congressional district, initiated a model suicide prevention program and, of course, is now involved with the national effort.

As you indicated, Mr. Chairman, suicide is the fastest growing cause of death among young people in the United States. Automobile accidents are the only cause of death for this age group that now surpasses suicide and it is an open question how many automobile deaths are, in fact, unconsciously related to a suicide wish. About 6,000 young people take their own lives each year as adolescents. If we realize that there are 10 times as many attempts at suicide as there are successful suicides, we are dealing with approximately 60,000 of our young people who in this society of historically unprecedented opportunities are taking this ultimate fatal step of attempting to take their own lives.

The new phenomenon of cluster suicides, suicide by contagion, striking affluent communities in many States indicates that this issue cuts across socioeconomic, religious, racial, ethnic, and all other lines.

Now there are many causes of youth suicide but I think it is clear that they include feelings of growing rootlessness and isolation, drugs, alcoholism, loss of parents, alienation from family and society, low self-esteem—all of these and many others are contributing factors. There is a great deal of anxiety and uncertainty about the future, both in the personal as well as the national context. There is anxiety about nuclear war, anxiety and uncertainty about personal employment opportunities, hurts and humiliations and fears and anguish—all are contributing factors.

Federal efforts in this field, Mr. Chairman, are pathetically inadequate. Funds for suicide prevention have all but disappeared in the past decade and funds for research on suicide are given no priority whatsoever in the National Institute of Mental Health. There is a tiny unit in the Division of Extramural Research Programs which is charged with the responsibility for research projects, but it has no funding of its own for such projects. Under the current administration policy projects addressing suicide issues must compete with all other health projects and programs for limited funds. Despite the rising rates, youth suicide has not been identified by the Department of Health and Human Services as a research funding priority area. When funding is made available, the agency bias is clearly toward support of biochemical medical research. The psychological, sociological and contextual issues surrounding youth suicide appear to be secondary to the discovery of a malfunctioning body chemistry. Funds for prevention programs are practically unavailable.

Now we recently had a conference, a national conference on which very little concrete follow-up action is planned. It was, by Washington standards, a poorly attended conference where most of the attendees came at personal expense. My judgment is that the administration is basically engaged in a public relations effort to prevent congressional action. And if you will allow a diversion, Mr. Chairman, I find yesterday's sudden conversion of the administration to sanctions on apartheid parallel to what we see in this field; namely, it is a public relations gesture designed to prevent long overdue congressional action.

My legislation, Mr. Chairman, H.R. 1894, which, by the way, was a good year, enjoys the broadest possible bipartisan support. It does, as it should, because if there ever was an issue which is nonpartisan, suicide among young people is certainly that issue. Some of our most conservative Republican colleagues, and some of our most liberal Democratic colleagues are sponsors of my legislation.

The legislation calls for two levels of action. It calls for a full-scale study of the problem to determine what action the Federal Government must take, and what action is effective and appropriate. It calls for an interdisciplinary commission of experts so that findings and recommendations as to the causes of youth suicide could be made available nationally, and then carefully studied for action. It also calls for community and school-based model programs for youth suicide education and prevention. These would be funded through a grants competition.

Now the administration gives the appearance of interest in this issue but is unwilling to commit resources to a serious search for solutions. The administration created its own interagency task force to deal with this problem, which I suspect would be comparable to the Pentagon establishing its own committee to study waste in the Defense Department.

The time is long overdue to bring knowledge and expertise from outside the bureaucracy to bear on this issue. It is very unlikely that a task force of overburdened bureaucrats will come up with innovative solutions.

In conclusion, Mr. Chairman, I simply cannot understand that a problem which in terms of seriousness approaches the AIDS epidemic, only it is less visible, should be given so little attention and so little support by our Federal Government. I invite your own personal support of this legislation and the support of distinguished members of your committee. We simply cannot allow tens of thousands of our young people in an age of unlimited opportunities to take their own lives foolishly, unreasonably and, obviously, with an air of finality, for lack of a bit of Federal attention.

Thank you, Mr. Chairman.

Chairman **Hawkins**. Thank you, Mr. Lantos, for a very excellent statement.

The Chair would like to get one understanding from you. In what way does your approach to the problem differ from the Ackerman bill?

Mr. **Lantos**. Well, let me first say, Mr. Chairman, that I am very proud to be a cosponsor of Congressman Ackerman's bill. I think it is an excellent piece of legislation and I would love to see it pass.

As I understand Congressman Ackerman's legislation it deals basically with one of the two facets of my legislation; namely, a grant program. I think that facet is an important facet. I think there is an equally important facet however; namely, to bring the best experts in the country in the private and in the public sector together so we can understand the causes of youth suicide.

If you look back historically, Mr. Chairman, and study the history of suicide, invariably people who committed suicide were not young people. They were either elderly people who for reasons of poor health, loss of a spouse, an inability to provide for themselves threw in the towel at the end of a long, difficult and hard life, or it was people in mid-life who for some reason—loss of a child, loss of a job—somewhere along life decided that it was just not worth it. We have never, never, Mr. Chairman, had the historical phenomenon of 14-, 15-, 16-year-old kids with unlimited opportunities taking their own lives.

Therefore, I feel that the facet of my legislation which creates this national commission of experts covering the fullest spectrum of disciplines that have a bearing on youth suicide is an important facet. I see no difficulty in combining the two pieces of legislation. And again I want to pay public tribute to my colleague Congressman Ackerman.

Chairman HAWKINS. Thank you.

Mr. Kildee.

Mr. KILDEE. I want to commend Mr. Lantos and Mr. Ackerman both for addressing this issue. The Federal Government has not done much. My own subcommittee, which has jurisdiction over the Runaway and Homeless Youth Act, has discovered that 60 percent of children who visit the runaway centers in New York City, have contemplated or actually attempted suicide. I guess the ultimate runaway in the minds of some of these children is suicide.

I think it is really something that we can direct our national resources toward trying to find some solution to it because it is a phenomenon that unfortunately is growing. And I commend both of the gentlemen for their interest in this, Mr. Chairman.

Mr. LANTOS. I thank my good friend, Congressman Kildee.

Since we are living in a period of $200 billion deficits allow me, Mr. Chairman, merely to indicate that the commission facet of my legislation calls for a one-time $1.5 million appropriation which would come to approximately two-thirds of a penny per citizen in the United States, as a one-time expenditure, to find out what makes these young people commit suicide. Purely on a financial level if we were able to save only some of these young people from killing themselves, their contribution to the economy over their lifetimes would pay many times over for this infinitesimally small amount.

Mr. KILDEE. We spend so much money learning how to kill people, it will be good to spend money to prevent killing, wouldn't it?

Mr. LANTOS. Well, if there is one argument that won't cut against this piece of legislation it is the budgetary argument. Because if you can't spend $1.5 million to find out why young people kill themselves our priorities are somewhat off.

Mr. KILDEE. Thank you, Mr. Chairman.

Chairman HAWKINS. Mr. Fawell.

Mr. FAWELL. No questions, Mr. Chairman.

Chairman HAWKINS. Mr. Martinez.

Mr. MARTINEZ. I also would like to commend the both of you, Mr. Ackerman, and yourself, Mr. Lantos, on these two pieces of legislation. There is a particular reason. I have a very close friend whose son, who seemingly had no problems, committed suicide. It is difficult to this day to understand why he did it. I think the parents were the last ones to recognize any symptoms. If they had had a little more knowledge about what causes young people to commit suicide that one might have been prevented.

But the thing that comes to mind when I think about these two bills—incidentally, I am cosponsor on both of them—is that there is so much drug abuse now and so many of these suicides are related to drug abuse, and that is a growing problem. So I think it is time to do something about it.

I would like to know where the United States ranks among the nations as far as suicide rate?

Mr. **Lantos**. It ranks among the highest in terms of youth suicide. It may be the highest. There are a number of nations, some of the Scandinavian countries, my own native country of Hungary, which rank higher in terms of overall suicide rates. But in terms of youth suicide the United States is among the highest, if not the highest. The reason we have trouble giving a precise answer is because many countries do not keep suicide statistics by age level.

Mr. **Martinez**. Yes, I imagine they wouldn't. You know for many years suicide has been thought of as sinful, something really bad. I remember my teachings as a young boy in the Catholic religion that to commit suicide is a mortal sin.

Mr. **Lantos**. That is right.

Mr. **Martinez**. And there are a lot of people that carry this thought forward.

Has anybody, and when I asked the question I was asking in terms of youth and I imagine we are probably one of the highest now. Has any other country or anyone anywhere ever tried to do some studies to determine this information?

Mr. **Lantos**. Yes. Several of the Scandinavian countries have studies on this subject which I think have some bearing on our issue. But I think the important thing in terms of our problem is that those of us who feel that many of the causes are sociological in character relate it to the particular features of the American social landscape. We feel that the causes here have to be studied in the United States. Just take the question of mobility. The very size of our country allows young people a degree of geographic mobility which in smaller societies is not possible. The need for a study related to the American scene is clear. There are no studies elsewhere which are directly germane to our problem.

Mr. **Martinez**. Well, I would agree with you in that for too long we have ignored suicide. And many times we have thought of it as just simply a psychological phenomenon.

Mr. **Lantos**. That is true.

Mr. **Martinez**. And it is really not. There are lot of emotional problems experienced by these young people that are connected with suicide. And I am glad to see this legislation being discussed. I hope it passes.

Thank you, Mr. Chairman.

Chairman **Hawkins**. Mr. Gunderson.

Mr. **Gunderson**. No questions, Mr. Chairman.

Chairman **Hawkins**. Mr. Lantos, I suppose that exhausts the committee in terms of questions.

Mr. **Lantos**. Thank you very much, Mr. Chairman.

Chairman **Hawkins**. We again commend you on your very excellent statement, and certainly this committee will give serious consideration to this legislation and we appreciate your contribution.

Mr. **Lantos**. Thank you. I just want to extend my apologies to my friend and colleague. But I have a 10 o'clock meeting with Secretary Hodel on off-shore leasing and that is why I am leaving.

Chairman **Hawkins**. Thank you.

The next witness is a former colleague on the committee, Mr. Ackerman.

Mr. Ackerman, I think it was at your request to the Chair that we called this meeting and we certainly appreciate your continuing interest in the subject of this committee. We look forward to your testimony.

STATEMENT OF HON. GARY L. ACKERMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. Ackerman. Thank you very much, Mr. Chairman. And thank you to my colleagues on the committee. You have my very deep appreciation and gratitude, and the gratitude of millions of American families, for calling these hearings on what has become a modern American tragedy—teenage suicide.

Over the past few years, this problem has been vividly brought into our living rooms through television dramas, news broadcasts, the daily newspapers, and magazines. Most of us can only imagine the effect that the loss of a young person has on family and friends. Yet thousands of children are cut down each year by their own tender hands. Young lives with bright and shining futures are lost forever.

Teenage suicide has, indeed, reached epidemic proportions, as Congressman Lantos has pointed out. The facts are plain: half a million young people try to take their lives each year, 5,000 of them succeed. Clearly, we are not doing enough to reach out to these troubled youngsters. We must declare war on this new scourge of America's teenagers.

Our Nation cries out for ways to prevent the loss of our most valuable resource—our children.

On February 19 of this year, you, Mr. Chairman, joined Congressman George Miller, the distinguished chairman of the Select Committee on Children, Youth, and Families; Congressman Mario Biaggi, my friend and colleague from New York; and myself in offering legislation that we believe is a responsible and necessary measure to combat the teen suicide epidemic.

Our bill, H.R. 1099, the Suicide Prevention Act, now carries the names of 32 cosponsors. Other Members of Congress as we have seen have joined with us in this very important crusade, especially our dear colleague, Congressman Lantos of California, who has shown great leadership in this issue and who has testified concerning his bill on this very, very important matter. Our breakthrough legislation, the Suicide Prevention Act—would create a small grant program within the Department of Education. The Secretary would select proposals from local education agencies to design, organize, and operate suicide prevention programs. This bill, if enacted, would authorize the grants for 3 years under an annual cap of $10 million. No group or school board could receive more than $100,000 in any one year. The programs that would be developed with the help of this legislation would reflect the valuable input of parents, community leaders, as well as that of school personnel and other experts. This approach, then, takes the talents and expertise of all segments of the education and youth service fields and focuses them on the important task of saving the lives of America's kids.

Mr. Chairman, the tragedy of death has no respect for borders. Troubled children are indigenous to no region. Geography, education level, income, ethnicity, religion, gender, social strata—none of these is a limit on teenage suicide. This plague can strike youngsters in Skokie, Pacific Palisades, or Scarsdale just as easily, just as quickly, and just as fatally as it hits children in South Chicago, Watts, or Harlem. In the past there has been no Federal commitment to stop teen suicide in any of these neighborhoods, rich or poor. Some schools have improvised programs, but these random efforts have usually come too late, only after the loss of a young life.

Teenage suicide is a national problem and cries out for a national response. H.R. 1099 by saving innocent children and sparing families excruciating agony responds to a void that the Federal government can and should help fill. Mr. Chairman, any loss of life is tragic. The loss of a child is devastating. The self-inflicted death of a young one is an unthinkable horror; yet, think about it we must, so that we can understand it and prevent it.

Thank you very much, Mr. Chairman.

Chairman **Hawkins**. Thank you, Mr. Ackerman.

Mr. Kildee.

Mr. **Kildee**. I commend Congressman Ackerman again for his sensitivity and knowledge in this area. It is an area where we are just scratching the surface as to the causes in order to seek some type of prevention. As one who is raising three children now, whenever I read of this happening it really tears into my own heart. You wonder why someone whom you think has so much of their life ahead of them would contemplate this. And we really have to know. We spend so much money determining other things in this country that it would be appropriate for this Congress to authorize appropriations for effective programs in this area.

Thank you, Mr. Chairman.

Chairman **Hawkins**. Thank you.

Mr. Fawell.

Mr. **Fawell**. Just one question. I note in a table I have before me that apparently the suicide rate among young people in Austria, Canada, Norway, Poland, and Switzerland especially, is higher. Do you know in those countries if there are efforts similar to what you envision taking place, or have they taken place? This would give us some idea of what our efforts might encompass?

Mr. **Ackerman**. I don't know that anybody has made a comparable study of the causes of teenage suicide and whether the causes are similar for different national cultures. I am unaware of any that have been made. And neither the bill that I have proposed nor Congressman Lantos' bill which I, too, fully support. I would have no objection to incorporation of both of them under a single piece of legislation, neither of us addresses the possibility of comparable studies between various nations. I think that might be a next step. But I think the thrust of our legislation addresses this as a national problem at least as a first step.

Mr. **Fawell**. I thank you.

Chairman **Hawkins**. Mr. Ackerman, as both you and Mr. Lantos stated, the causes are not clear or practically unknown. Would those of us who are sponsoring this piece of legislation be faulted on the basis that we are attempting to correct a problem the causes of which are not known and that we are pinning down in a sense an approach which is not related to a specific cause or set of causes? How would you respond to that criticism?

Mr. **Ackerman**. Well, I don't know that even upon studying that we would be able to pin down the problem of teenage suicide and blame it on a specific cause or group of causes other than a general type of disturbance. Drugs I think might be the exception to that. I think that Congressman Lantos' legislation which calls for a national conference certainly has an aspect that I had not considered under this legislation and certainly would have no objection to. Certainly no harm could come out of that and it certainly would focus greater national attention on this problem. As a matter of fact, I would fully support such a conference. The inclusion of that into this particular legislation causes it to be the subject of jurisdiction of a second committee besides the Education Committee, but I would have no objection to that conference. I certainly would support it.

Chairman **Hawkins**. Thank you.

If no further questions, then, again we appreciate your appearance before the committee, Mr. Ackerman.

Mr. **Ackerman**. Thank you, Mr. Chairman.

Chairman **Hawkins**. Thank you.

The next witness is another Member of the House. We are very delighted to have the Honorable Joseph DioGuardi, a Member of Congress from the State of New York.

And, Mr. DioGuardi, we look forward to your testimony this morning.

STATEMENT OF HON. JOSEPH J. DioGUARDI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. **DioGuardi**. Thank you, Mr. Chairman.

I am pleased to be here this morning to discuss what I have come to believe is a major and growing problem in our country, a problem yet to be completely understood and recognized. This is the problem of youth suicide.

We are all here today because we care about our young people. Young people are under much pressure in contemporary society and are forced to grow up very quickly. Obviously, today's kids are growing up in a world vastly more complex than the world we grew up in a generation ago. Very early in life young people are forced to take responsibility and proceed with their lives, many times before they are emotionally ready to do so.

As a U.S. Representative and as a father of two young children, I am concerned about what the institution of Congress can do, and should do, to first understand then help alleviate the problem of young people taking their own lives.

My district, Mr. Chairman, the 20th Congressional District in Westchester County, NY, is clearly a cluster zone for teenage suicides. Unfortunately, in the last 18 months, close to 20 young people took their lives in my district. Even more intimidating and painful is the fact that I have often heard statistics that for every suicide of this nature at least 100 additional attempts are made but never reported. If this is the case, we have a great many young people in need of our help and I believe the Federal Government has a role to play in this mission.

Senator Jeremiah Denton and I introduced House Joint Resolution 193 last March that designated June as Youth Suicide Prevention Month. Because of the concern of our Senate and House colleagues, we were able to garner the necessary support for passage and President Reagan signed the bill into law last May. This was a good means of publicizing the need for more public awareness of the issue but it was only the beginning of what must be done.

Representatives Lantos and Ackerman both have excellent youth suicide prevention legislation and I applaud their leadership and expertise in this vital area. I fully support the thrust of their legislation and I hope we can all work together to ensure passage and to secure Federal funding.

The superb work of Charlotte Ross and Ursula Meese of the Youth Suicide National Center here in Washington has prompted me to become involved with lending my background as a certified public accountant and a businessman to the effort of youth suicide prevention. I believe that if we can secure Federal funding, we must treat every dollar as a scarce commodity, which they are these days, and spend them as efficiently as possible. We must maximize every resource we have in these times of budget crises.

One area that I am extremely interested in exploring is the notion of diversifying our resource base so as to aggressively pursue funding from private sector sources. As well as being a CPA, I was heavily involved in fundraising activities for charities like the Phoenix House Foundation, the American Cancer Society, and the Boy Scouts, to name some—organizations that have made major contributions to our society. There is much we can do to get the private sector involved in the area of youth suicide prevention, and I am currently studying the means to do so. The Federal Government is an ideal place to acquire the seed money for a national commission and grants as envisioned in the legislation already introduced. Yet I believe the exploration of private sector financial sources is essential to any long-term effort to stem the growing problem of young people taking their lives.

In closing, I want to say that youth suicide prevention is not a partisan issue, we all realize that. It is an issue that we can all get together on and rally around because the greatest resource we have in this country are our youth, and they need our help. I believe that together we have the tools to make an effective and lasting mark against the problem so painful to us all. I really appreciate the opportunity to be here with you, Mr. Chairman, and thank you.

Chairman **Hawkins**. Mr. DioGuardi, we certainly appreciate your appearance before this committee and very excellent statement which presents certainly a wholesome point of view, and we commend you on your interest in this particular problem.

Mr. Fawell.

Mr. **Fawell**. No; I have no questions. Thank you.

Chairman **Hawkins**. Mr. Kildee.

Mr. **Kildee**. I commend Congressman DioGuardi. He and I have had some good chats on the floor on various subjects, and I think you illustrate very clearly there, Joe, that this is an issue that transcends party. Your leadership in this has been very, very helpful, and I hope we are able to do something effectively in this area. Thank you very much.

Mr. DIOGUARDI. Thank you.

Chairman HAWKINS. Mr. DioGuardi, you see no conflict at all in the three bills; you would support the ideas, basically, the ideas contained in the other two bills as well?

Mr. DIOGUARDI. Yes, I would, Mr. Chairman. I think the idea of the grants as seed money to localities and nonprofit organizations is a great idea, and I think the idea of a national commission is very important because we know very little about the motivations of these young children in taking their lives, in taking that final step. And I think we must explore why it is today that in a society as well developed as ours that we have these kinds of acts.

I talk about my own county. Westchester County is considered as one of the most affluent counties in the United States, and yet I am told that my county is either No. 1 or very close to it in the number of teenage suicides. It must give one pause for reflection that we must be putting tremendous pressures unwittingly, parents and society, on these young children and at the same time we are not developing the means of communication with these young children. Somehow the ability to get things off their chest is not there whether it is in school, whether it is in the context of the family, and whether it is in certain other institutional modes in society. So we have got to understand what it is that is causing people to even think this way, and we have got to look at the ways to diffuse this kind of pressure so that kids are able to talk to others about their problems.

I have heard the stories before, and one situation that you mentioned before, Mr. Kildee, and that is the situation where you have suicides that no one could ever anticipate. In fact, just before they happen. In a couple of cases in my county the child never felt so good, and I have talked to psychiatrists about that and the feeling there is that the child was very confused and disturbed and finally made an emotional decision to do this and was at peace with him or herself. But behavioral patterns are very important in looking for these potential disasters and tragedies.

So I am going to try to stay out front on this issue not only as a Congressman but as a community leader. I still am very actively involved in many charitable organizations back in my district. I am a new Member of Congress and really my background for the job was not politics, I was in business all my life but was being actively involved on the boards of charitable, civic, and cultural organizations.

And I believe strongly today that there is a place for the Federal Government to play a role when it comes to funding. As you know, I am a fiscal conservative. I ran on both the Conservative and Republican lines, and I feel strongly about issues such as teenage suicide and child abuse, and I think there is a way for us to do it. But we have got to do it looking at the Federal Government as the way to generate more money in the private sector, and that is the area that I am going to consistently explore to see if we can get the corporate community to play a broader role in meeting that social responsibility on these issues as well.

Chairman **Hawkins**. Mr. Ackerman, do you wish to make a comment at this time?

Mr. **Ackerman**. Thank you very much, Mr. Chairman.

Let me commend Congressman DioGuardi, both for his excellent statement and for his superb leadership that he has given in the area of teenage suicide. He has already made his mark on this Congress even as a very, very new Member of our body. And of course he and I maybe share different ends of the political spectrum on many issues, but this has brought us together as I am sure it will many Members of this body.

As Joe points out, his particular area of the State of New York happens to be, and I think he might have understated it, a rather affluent—underlined—area of the country. Despite this there were what I think we could consider a wave or a rash of suicides of children who were successful by any type of measurement that we would want to apply, both socially and academically, children who seemed to be rather well adjusted; who came from decent, good families; who were successful in their academic careers; and yet one after another from one or two or three schools in a period of several months seemed to take their own lives for absolutely no apparent reason, one after the other. And this is a problem, Mr. Chairman, that certainly bears great attention by this body, and I thank you for conducting these hearings.

And, Congressman DioGuardi, I thank you for your support of the legislation that is before us.

Mr. **DioGuardi**. Thank you, Mr. Ackerman, for those kind comments and your leadership on this issue.

Chairman **Hawkins**. Thank you again for a very excellent statement and we are appreciative of your concern and your appearance before the committee.

Mr. **DioGuardi**. Thank you, Mr. Chairman.

Chairman **Hawkins**. Thank you.

The next witnesses will consist of a panel composed of Ms. Charlotte P. Ross, president/executive director, Youth Suicide National Center, Washington, DC; Ms. Debra Meckley, school social worker, Family and Children's Service of Lancaster County, PA, representing the National Association of Social Workers; Mr. Fred Wyatt, a student from Arlington, VA; and Mr. John Carswell, executive director, Parson's Child and Family Center, Albany, NY, representing the Child Welfare League of America.

Would those witnesses please be seated at the witness table.

Ladies and gentlemen, we will call on you, then, in the manner in which you were scheduled, Ms. Ross being the first witness. We welcome this panel. We look forward to your testimony.

STATEMENT OF CHARLOTTE P. ROSS, PRESIDENT/EXECUTIVE DIRECTOR, YOUTH SUICIDE NATIONAL CENTER, WASHINGTON, DC; DEBRA MECKLEY, SCHOOL SOCIAL WORKER, FAMILY AND CHILDREN'S SERVICE OF LANCASTER COUNTY, PA, REPRESENTING NATIONAL ASSOCIATION OF SOCIAL WORKERS; FRED WYATT, STUDENT, ARLINGTON, VA; JOHN CARSWELL, EXECUTIVE DIRECTOR, PARSON'S CHILD AND FAMILY CENTER, ALBANY, NY, REPRESENTING CHILD WELFARE LEAGUE OF AMERICA

Ms. Ross. Well, thank you very much. My testimony is going to be informal, but I am very appreciative for the opportunity to speak before you on an issue that obviously I consider to be of great importance.

I am Charlotte Ross. I am director of the Youth Suicide National Center in Washington, which is a new organization dedicated to responding to the national problem of youth suicide.

I wanted to begin by mentioning some of the national statistics and the broad picture. I think you all are aware of those. I think the one comment I would make about the expanding rates of youth suicide is that they are only the most visible tip of what is an iceberg-like problem of depression and self-destructiveness. The rates of death tell us we have a problem but not its size or complexity. Let me try to illustrate that with some picture of the national rates and also respond to a couple of the questions that were raised as far as international rates.

Nationally, we know that between 5,000 and 6,000 young people are known to have taken their own lives; that is, the coroner certifies those deaths as suicide. We also know that far too many young people actually try to take their own lives. How many we are not certain of. It is suicidal behavior that is also a major problem. How many of our young people quietly, secretly attempt to take their own lives and by the grace of God survive never telling another adult, never reporting it to a medical authority. And when they do tell, if they tell, they usually tell a peer, a friend.

What our numbers tell us is that in surveys across this country of general high school students approximately 11 percent of our high school seniors will tell us that they have made at least one suicide attempt at some point in their life. If you apply that number, 11 percent, to the general population, you would find that there have been more than 2 million youngsters in this country who have attempted suicide by their report. We also find that approximately 40 to 50 percent tell us that they have considered suicide to the point of planning it, how and when they would do it.

The commonest experience reported in this country, and that is reported in about 70 percent of the instances, is a high school student telling us that a classmate, a friend, has turned to him or her and confided that that friend is considering suicide and pledges the confidante to secrecy saying don't tell anyone, this is what I am going to do, and implying if you can help me, do; if you can't, that is OK; but please don't interfere or don't tell an intrusive adult.

Let me, before going on to the implications of that, some of us who have worked with suicide prevention for a while have felt that two major approaches—not the answer, not the solution—but some approaches that might help would be to help youngsters learn how to help their friends and themselves better, to help the people around youngsters learn to recognize the signs of suicide; hence, of course, Congressman Lantos and Congressman Ackerman's bills are very much on target. Education is one major avenue to preventing youth suicide.

I do want to mention briefly before I go on to the next point in response to the questions about the international picture I think it is marvelous as I hear all of you and those who testified respond knowledgeably to these questions because it is an example of what education can do. You, in developing this legislation, Congressman Ackerman, have a much broader knowledge than I would imagine you did a year or two ago about the problem of youth suicide, and you pass that on to your colleagues and they pass it on, and we all have children and that is what the answer is about.

Switzerland does have the highest rate reported of all the countries reporting to WHO. The World Health Organization and countries throughout the world are concerned about the issue of youth suicide. In 1974, the World Health Organization called a meeting to address this issue because the escalating rates in the United States were also taking place throughout Europe. Interestingly, years ago when WHO did inquire of all countries for their rates the response they got from the Soviet Union was simply a one statement response, which is suicide is not a problem in the Soviet Union. So we have no statistics on most of the Iron Curtain countries and not on Russia.

We do have other countries trying to deal with the problem, and not surprisingly many of them are looking to the United States for leadership. There will be a representative from WHO visiting Washington next month as WHO is now in the process of trying to set up a task force to deal with this problem. The United States, we have already. Our Health and Human Services has set up a task force to deal with it. Our legislators are working on it.

Let me take a look for a moment with you at what we do know about the problem and the existing resources we have and what approaches might be involved. It is my biased opinion that with a problem of the magnitude of youth suicide what is needed is everything. Everything and every one. What we need are educators, community leaders, government leaders, parents, peers, corporate leaders, youth service providers—all of the organizations working in this field. And I should mention that we have many organizations already committed as you legislators are to trying to do something about this problem. The American Association of Suicidology has taken an active role in dealing with it. The American Psychiatric Association, the American Psychological Association, the American Medical Association—all are producing literature on youth suicide informing their constituency, their members, of the latest information on youth suicide and what to do about it. The American Academy of Pediatrics just put out some new materials. It is this vast utilization of this country's resources to deal with the problem that I think will turn it around.

I do just want to mention a couple of things and then I will be happy to respond to any questions that you have. I think that we can mobilize the resources of this country so effectively that while we have watched for 25 years this mounting rise in our statistics that you will see in the next couple of years a very marked decline. I think that is possible. I think it is possible because of the leadership of a number of people, and certainly your leadership, in showing each one of us that we are going to work together, the Federal Government and the private sector.

Your approach, Congressman Ackerman, in this bill in education is a very important one, and I think there is education taking place in this room and we have a lot of educators out there. You have the media. And if you will notice—one of the things you might want to do is look at the articles that have come out in the past year on youth suicide and compare them to those that came out years ago. Now when the newspapers write up the issue of youth suicide please note that they contain almost always a list of signs to watch for, things to do, resources to call. They have joined us in partnership in being one of our Nation's greatest educators.

I was proud to be a consultant to "Silence of the Heart," to have CBS say that if it will be helpful, we will take the story of youth suicide into the Nation's living rooms and educate parents and the public on what to do. And I am very, very pleased that our Federal Government is taking a leadership and an appropriate role. And all I can say is I am delighted to join with you from the private sector and see how we can all mobilize everyone to respond to youth suicide.

I will be happy to respond to any other questions, and I will close my testimony with that. Thank you.

Chairman. HAWKINS. Thank you, Ms. Ross.

The next witness is Ms. Debra Meckley.

Ms. Meckley, we welcome you.

Ms. MECKLEY. Thank you, Mr. Chairman, members of the subcommittee. My name is Debra Meckley. I am here today on behalf of the National Association of Social Workers. The association has almost 100,000 members organized into 55 chapters across the country.

I am a social worker, and I am employed by Family and Children's Service of Lancaster County in Lancaster, PA. Family and Children's Service is a private, nonprofit counseling agency which is supported through the United Way. I spend about 80 percent of my time practicing in the Solanco School District in Lancaster County, which is a rural school district, and this school district contracts with my agency for school social work services.

In addition to my assignment as a school social worker, I have also been a program coordinator of an Adolescent Suicide Prevention Program which began at Family and Children's Service about 5 years ago. This program is known as Project ALIVE and it is a primary prevention model aimed at helping school administrators, faculty and students understand, identify and help the potentially suicidal teenagers. The project has been a joint effort between Lancaster County schools and mental health agencies in the community.

The program started as the result of a suicide of an eighth grade boy who shot himself in a Lancaster County school district. Shortly after that suicide there was a series of three suicide attempts in the Solanco School District, and the result of that were school superintendents who were, of course, deeply concerned about the events and also concerned about the reactions of other students. I think when something like this happens in a school district, either a suicide or a series of very serious suicide attempts, there certainly is a lot of bewilderment about why has this happened and a lot of unanswered questions. There is certainly the normal grief that goes along with any kind of a death, but I think in a suicidal death there is a lot of guilt of survivors, particularly the peers that may have had information or may have been told prior to the suicide that the person was contemplating it.

I think the school superintendents were very concerned but felt that they did not have the personnel with the expertise to handle the situation and, therefore, they contacted our agency. The interventions that we had planned at that time in the school districts involved an in-service program with teachers and administrators and we also conducted classroom discussions for students, and all of these were conducted by an agency social worker.

Prior to the classroom discussions we asked students to write down the questions that they had about suicide, and from a total of approximately 700 students in these two school districts they submitted 92 different questions that were related to suicide. After we examined and collated the questions the decision was made to turn them over to the Family and Children's Services Advocacy Program with the purpose being to set up a committee, or what we call a study action team, to analyze the need for increased education and services in adolescent suicide prevention and to determine methods for fulfilling those needs.

The study action team consisted of myself, other mental health professionals, parents, and teachers. After studying the community, the county that is served by our agency, the study action team concluded that many school districts were really not adequately addressing the problem of adolescent suicide. I think they were dealing with students experiencing emotional difficulties on an individual basis but not as an overall program. The group also concluded that while community resources and expertise were available to schools they were generally used as intervention and post-intervention and not in a preventative way.

A major component of Project ALIVE is a lesson plan which can be used for educating adults and students about adolescent suicide. The lesson plan was based on the questions that were submitted by students and include sections on factors contributing to suicide, statistics, warning signs, strategies for helping troubled teenagers, coping skills for teenagers, and then descriptions and telephone numbers of available community resources.

Since the target population for prevention was teenagers we felt that schools were the logical focal point for initial intervention. A second component of the project involves in-service training for administrators, teachers, guidance counselors, school nurses, peer counselors and students. The goals of the training are twofold: educational and supportive. I think the informational part of this is very important. I also feel that the supportive element was equally as important because it is effective in addressing potential opposition to the program and it also eases some fears about the subject.

In the last 3 years since Project ALIVE was published, 195 copies have been distributed to all 16 school districts in Lancaster County and throughout the country. National publicity was provided by presenting details of the program at the NASW National Conference on School Social Work early in 1985, and that conference was attended by about 1,000 school social workers. Also, recently a Lancaster County bank has awarded the agency a grant to publish an additional 1,000 copies of the lesson plan.

So it is out of my experience in this Lancaster school system and in my involvement with Project ALIVE that I would like to express my overall support of H.R. 1099 and H.R. 1894. With regard to H.R. 1894 I would really like to commend the sponsors for their acknowledgement of youth suicide as a national health problem which needs to be addressed on a Federal level. While States and localities I think are very adept at tailoring specific programs to meet their local needs, the Federal Government I feel must serve as a catalyst in stimulating the development of comprehensive suicide prevention programs. My experience has been that local schools and agencies tend to be reactive, and by that I mean that they tend to take action after such a tragedy has occurred rather than organizing a primary prevention effort.

I also support the proposal set forth in title I of H.R. 1894. I feel that the coordination of research and treatment models is certainly a necessity for effective and efficient prevention programs. The emphasis on multidisciplinary approaches in section 2(3) I also feel is an essential component. This principle is also a feature of the approach to helping handicapped children as entrenched in Public Law 94-142, the Education for All Handicapped Children Act. However, in H.R. 1894 the recommendation composition of the commission is somewhat limited in scope. Section 2(2) emphasizes the need to integrate data about the physical, psychological and social conditions associated with suicide. Section 104 of title I provides for strong expert representation in the physical and psychological but I think needs some strengthening as far as social factors are concerned.

Social work as a profession has expert knowledge of socioeconomic, cultural, community and family factors which influence social problems such as suicide. The organization and coordination of community resources are also social work skills which I think would contribute to the planning for the prevention of youth suicide on a national level. I would, therefore, recommend that the bill include some provision for the appointment of two social workers as members of the commission. And I know that the National Association of Social Workers would be very happy to assist you in recommending social workers with related expertise.

Title II of H.R. 1894 I think is an important component of any thorough primary prevention program. Community resources must be available to schools to assist in carrying out such programs. However, in my view, the primary responsibility for youth suicide programs should lie with school systems. My reasons for that are that of all the agencies and institutions in this community schools have the most immediate access to the greatest number of children and youth.

Students routinely attend school and you can consider them as a captive audience so that they are amenable to both academic instruction about issues as well as supportive services. Also, teachers are in a unique position to observe students over an extended period of time and to monitor changes in behavior which may be indicative of potential suicide. If we look at it from the students' point of view, I think it is much more convenient to seek help from support staff within a school than from clinics or agencies outside of the school system. Therefore, it is my view that schools are the most effective and efficient base for suicide prevention programs. Outside resources from the community should be used when more intensive help is given, but the primary focus of intervention should be schools.

In relation to H.R. 1099, I support the four program requirements stated in section C of the bill. My concern is that many schools do not have adequately trained staff to deal with this problem. As I mentioned before with Project ALIVE, that began with the recognition by a local educational agency that it lacked the personnel with the expertise to handle student reactions to suicide and suicide attempts. Therefore, the school system approached our agency to provide that service. While we provided the service, and I think we have done a very adequate job of providing the service, to me the ideal program should be coordinated by someone with the school such as a school social worker who is employed by the school.

I think having a professional person within the school lends continuity to a program that cannot be assured by an outside agency. A school social worker can also provide expert knowledge about resources within the school system itself and can serve as an effective link with the resources in the community. Thus, I feel that he or she could combine the resources of the multidisciplinary pupil services team within the school which would include school social workers, school psychologists, guidance counselors, school nurses, and others with the professional expertise and services in the community.

The model that I am talking about here actually is in existence in some school districts. For example, the Fairfax County public school system in Virginia, suburban Washington, DC, they have school social workers who coordinate an adolescent suicide program and that program has received national attention.

I would recommend that H.R. 1099 include a provision for the hiring of school social workers as a condition for receiving grants. In my experience, school social workers would be ideally qualified to fulfill the program requirements of H.R. 1099.

That is the end of my testimony. The National Association of Social Workers and Family and Children's Service would certainly be willing to be of further assistance in the process of establishing programs to combat the rising incidence of adolescent suicide. If we can provide you with additional information, we will certainly be available. And I would like to thank you very much for the opportunity to appear here today.

Thank you.

[The prepared statement of Debra M. Meckley follows:]

PREPARED STATEMENT OF DEBRA M. MECKLEY ON BEHALF OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

My name is Debra M. Meckley, I am here today on behalf of the National Association of Social Workers. The association has almost 100,000 members organized in 55 chapters, one in every State and in the District of Columbia, New York City, Puerto Rico, the Virgin Islands, and Europe. It is estimated that between 10,000 and 12,000 social workers are employed in elementary and secondary schools, and a far larger number work with the school-age population through family service agencies, mental health centers, clinics and hospitals, juvenile justice agencies, drug and alcohol programs, etc.

I am a social worker employed by Family and Children's Service of Lancaster County in Lancaster, Pennsylvania. Family and Children's Service is a private, nonprofit counseling agency supported through the United Way. However, I spend about 80 percent of my time practicing in the Solanco School District in Lancaster County which contracts with my agency for school social work services. In addition to my assignment as a school social worker working with learning disabled children and their families in a Chapter 1 program I have been the coordinator of an adolescent suicide prevention program which began about five years ago. This program known as Project A.L.I.V.E. is primary prevention program model aimed at helping school administrators, faculty, and students understand, identify, and help potentially suicidal teenagers. The project has been a joint effort between Lancaster County schools and community mental health agencies. The program started as a result of the suicide of an eighth-grade boy who shot himself in another Lancaster County school district. Shortly after this suicide, three high school students made suicide attempts in the Solanco School District, a rural district with about 2,000 students of whom about 600 are in grades 9 through 12. The school superintendents were deeply concerned about these events and the reaction of the other students. Feeling that the district did not have personnel with the expertise to handle this situation, the superintendent contacted our agency.

Interventions in the school district involved an in-service program with teachers and administrators, and classroom discussions for students, all of which were conducted by an agency social worker. Prior to the classroom discussions, students were asked to write down questions that they had about adolescent suicide. From these schools a total of 700 students submitted 92 different questions related to suicide. After examining and collating the questions the decision was made to turn them over to Family and Children's Service's Advocacy Program. The purpose would be to set up a committee or study-action team, to analyze the need for increased education and services on adolescent suicide prevention and to determine methods for fulfilling that need. The study-action team consisted of myself, other mental health professionals, teachers, and parents.

After studying the county served by our agency, the study-action team concluded that many school districts were not adequately addressing the problem of adolescent suicide, but were dealing with students experiencing emotional difficulties on an individual basis. The group also concluded that while community resources and expertise were available to schools, they were generally used as intervention and postvention by schools rather than as prevention.

A major component of Project A.L.I.V.E. is a lesson plan which can be used for educating adults and students about adolescent suicide. This lesson plan was based on questions posed by students in middle schools and high schools. Sections include factors contributing to suicide, statistics, warning signs in potentially suicidal adolescents, strategies for helping the troubled teenager, coping skills for teenagers, and descriptions and telephone numbers of available resources in the community. Since the target population for prevention was teenagers, schools were the logical focal point for initial intervention.

A second component of the project involves in-service training for administrators, teachers, guidance counselors, school nurses, peer counselors, and students. The goals of the training were twofold—educational and supportive. While the informational part of the in-service is important, the supportive element seemed most effective in addressing potential opposition to the program and easing fears about the subject.

In the last 3 years since Project A.L.I.V.E. was published, 195 copies have been distributed to all 16 school districts in Lancaster County and throughout the country. National publicity was provided by presenting details of the program at the NASW National Conference on School Social Work attended by a thousand people early in 1985. A Lancaster County Bank has recently awarded a grant to publish an additional thousand copies of the lesson plan.

It is out of my experience in working in the Solanco school system and in the Project A.L.I.V.E. adolescent suicide prevention project that I would like to express my overall support of both H.R. 1099, which would make grants available to local educational agencies for teenage suicide prevention programs, and H.R. 1894, which would establish a commission to study youth suicide and a grant program funding programs to prevent youth suicide.

With regard to H.R. 1894, the sponsors are to be commended for their acknowledgment of youth suicide as a national health problem which needs to be addressed on the Federal level. While states and localities may be adept at tailoring specific programs to meet their local needs, the federal government must serve as the catalyst in stimulating the development of comprehensive suicide prevention programs. My experience has been that local schools and agencies tend to be reactive, that is, getting involved after a tragedy has occurred rather than organizing a primary prevention effort.

I support the proposal set forth in title 1 of H.R. 1894 which would establish a commission to study adolescent suicide and develop a national plan for youth suicide programs. Such coordination of research and treatment models is necessary for effective and efficient prevention programs.

The emphasis on multidisciplinary approaches in section 2(3) is an essential component. This principle is also a feature of the approach to helping handicapped children as entrenched in Public Law 94–142, the Education for all Handicapped Children Act. However in H.R. 1894 the recommended composition of the Commission is somewhat limited in scope. Section 2(2) emphasizes the need to integrate data about the physical, psychological and social conditions associated with suicide. Section 104 of title I provides for strong expert representation in the physical and psychological areas, but needs strengthening in our opinion as far as social factors are concerned. Social work as a profession has expert knowledge of socio-economic, cultural, community, and family factors which influence social problems such as suicide. The organization and coordination of community resources are also social work skills which could contribute to planning for the prevention of youth suicide nationally. We would therefore recommend that the Bill include provision for the appointment of two social workers as members of the Commission. The National Association of Social Workers would be happy to assist you in recommending social workers with related expertise.

Title II of H.R. 1894 which would provide grants to States, political subdivisions of States, and private nonprofit agencies for prevention programs is an important component of a thorough primary prevention program. Community resources must be available to assist schools in carrying out such programs. However, in my view the primary responsibility for youth suicide programs should lie with school systems. The reasons are as follows:

Of all agencies and institutions in the community, schools have the most immediate access to the greatest number of children and youth. Students routinely attend school and are a "captive audience", amenable to both academic instruction about issues and supportive services. Teachers are in a unique position to observe students over an extended period of time and to monitor changes in behavior which may be indicative of a potential suicide. From the student's point of view, it is more convenient to seek help from support staff within the school than from clinics or agencies outside. Therefore, it is my view that schools are the most effective and efficient base for youth suicide prevention programs. Outside resources from the community should be used when more intensive help is needed, but the primary focus of intervention should be the schools.

In relation to H.R. 1099 which would make grants available to local educational agencies for teenage programs, I support the four program requirements stated in section C of the bill that is, that any program shall, (1) assist in increasing awareness about the incidence of teenage suicide, (2) train school personnel in strategies for prevention, (3) develop school-based prevention programs, and (4) utilize community resources. My concern is that many schools do not have adequately trained staff to deal with this problem. Project A.L.I.V.E., the suicide prevention program in which I have been involved, began with the recognition by a local educational agency that it lacked the personnel with the expertise to handle student reactions to suicides and suicide attempts. The school system therefore approached a family service agency in the community to provide the service. The service was provided by agency social workers and while an adequate program has evolved, the ideal program should be coordinated by a school social worker who is employed by the local educational agency itself. Having a professional person within the school systems lends continuity to the program which cannot be assured by an outside agency. A school social worker can also provide expert knowledge about resources within the social system itself and can serve as an effective link with the resources in the community. Thus, he or she can combine the resources of the multi-disciplinary pupil service team within the school—including school psychologists, guidance counselors, school nurses and others—with the professional expertise and services in the community.

This model exists in many school districts. For example, Fairfax County Public Schools, Virginia in suburban Washington, DC have school social workers who coordinate an adolescent suicide program which has received national attention. I would recommend that H.R. 1099 include provision for the hiring of school social workers as a condition for receiving grants. In my experience, school social workers would be ideally qualified to fulfill the program requirements of H.R. 1099.

The National Association of Social Workers and Family and Children's Service of Lancaster County would like to be of further assistance in the process of establishing programs to combat the rising incidence of teenage suicide. If at any time we can provide you with additional information, we will certainly be available. Thank you very much for the opportunity to appear here today.

Chairman **Hawkins**. Well, thank you, Ms. Meckley.

The next witness is Mr. Fred Wyatt, a student from Arlington, VA.

Mr. Wyatt.

Mr. **Wyatt**. Thank you, sir.

Today, I come to tell you about a friend of mine who had had problems in school, but our school had nothing for a person to have even in or out of school or around the neighborhood if you had problems which were held inside. My friend was at school several times a week, normal school days, and he would walk out of classes, and he would withdraw from parents. He would just walk out of school and leave for the rest of the day.

One day he left and he asked me to come along. So I went up to another friend's house of mine, up at Calvert Street, and I was sitting upstairs watching TV with my friend and he was downstairs talking to his girlfriend. She came upstairs to talk to me, and when we went back downstairs he was gone. So we both ran outside to see where he had gone and he was sitting on the Calvert Street Bridge.

I came out there and I said, you know, are you OK?

He said: "Don't bother me."

I said: "What do you mean don't bother you?"

He said: "No one cares. My parents don't care. My girlfriend doesn't care. Life doesn't care. No one wants to help me—my teachers, nobody. I'm doing horrible in school. The teachers say they don't care if I fail." He said: "Nothing is going right."

I said: "People care."

Right then a passerby stopped and said, you know, is he OK? I said he will be all right.

So I said: "See, even people who don't know you care." I said: "People will try to do their best for you even though they don't know you."

I said, you know, "You just have to think of life as a bunch of hurdles and sometimes some are high and sometimes some are low; and if you trip over one you just can't stop the race."

And you know, he started to cry and stuff, and we were just talking. As if he needed help, someone to lean on, but he didn't want to go as far as a teacher. It was almost as though he was afraid a teacher would tell his parents that he had the problem. But he needed someone he could rely on and talk on a peer level.

So he got back down off the bridge and, you know, we were just walking back to the house, and he said: "It's really tough for people to talk to people that are above my age and for me to relate to them and try to explain."

I said, you know: "You just have to go to your friends and if your friends can't help you, you have to go to your parents, and if your parents can't help you, you have to just do your best."

He has calmed down since then. He is back to normal.

But I think you need to—the little issue that came up with me was my mother had worked on the teenage suicide and she had brought home the pamphlets, and I had just browsed through them and picked up the signs of withdrawing, not seeing friends, change of moods quickly, change of attitude. I noticed that when my friend had this problem. I think there just needs to be awareness in school, not of a teacher or a counselor but someone you can talk to who doesn't have to be older than you, he can be a peer. There just needs to be someone he can talk to and they will have an equal understanding.

Thank you.

Chairman **Hawkins**. Well, thank you, Mr. Wyatt, for sharing your experience with us. We appreciate it, and we look forward to some questions I am sure from members of the committee.

The final witness in this panel is Mr. John Carswell, executive director of Parson's Child & Family Center, Albany, NY.

Mr. **Carswell**. Thank you, Mr. Chairman, and members of the subcommittee. On behalf of the Child Welfare League of America and the American Association of Children's Residential Centers I am pleased to be able to appear before you this morning to respond to the issue of teen suicide.

My name is John Carswell. As stated, I am executive director of Parsons Child and Family Center, an agency I have been with for 23 years. I have been executive director for 5 years. The agency was established in 1829. We are a multiservice agency. We provide many treatment programs for troubled young people and their families. We have residential treatment group homes, foster homes. We have adoption for special needs children. We have a child guidance clinic. We have day treatment. We have a number of resources and programs. And of course, because we do work with 1,400 children in a given year, and it will probably be 1,500 next year, we come into contact with problems of suicide or potential suicide.

I should mention to start out that our agency has never had an actual suicide amongst anyone that we have worked with. We have in our care right now, presently in care, 500 young people; about 20 who have made attempts at suicide through various means. And we certainly believe that another 25 to 30 percent of our population is at risk; without overt behaviors of suicide but indirect, such as overdrinking, over use of drugs, et cetera.

We have had suicides occur—three in the last 2 years—with young people mainly in their late teens who left our support programs and who are amongst what you have heard are the aged out population, the youth who have left, or many of whom have left the foster care system and are adrift in the community.

Let me give you a few examples of the types of children that we deal with in, and families, where there is an issue of suicide potential.

Vernon I found in our agency is the youngest child, age 5, whom we really felt showed many of the suicidal behaviors including jumping out of a kindergarten classroom window on his—well, during the first month he was there he jumped out several times and got injured both times. The child was referred by the school system to our prevention program which deals with trying to prevent kids from going back into foster care. The child was definitely depressed. He had a long history of placement, five or six foster home placements; a family of violence; a family where there had been many separations; his father had been in and out of jail—and going to school reactivated a lot of this young person's concerns about separation and loss.

Basically we have done quite well with the family. We have helped them identify some of the triggers that bring about the violence. The father went into alcohol counseling. And we are working with the family in learning how to have fun.

Alice is different. She is age 16. She has been in our residential treatment center for the last 6 months. She immigrated to this country with her family when she was 10. There was a lot of family difficulty in adjusting to this country. They are an upper middle-class family. Parents divorced. Mother tried to commit suicide. Alice followed and tried to commit suicide. And during the last 4 years she has been in and out of psychiatric hospital care.

Now this child is psychotic most of the time. She doesn't think straight. She thinks her psychiatrist is the devil. She has tried various methods of suicide including biting through an electric cord, taking an overdose of medication, trying to consume a bottle of Clorox, all issues such as that.

Carol, age 16, is another situation very different, too. Carol lives with her mother. Many of our children are single-parent household children. Not all, but many experience that. The parent and the child have a horrible relationship. They are really two teenagers. They compete for the same boyfriends. There is no parental support for Carol. Periodically she has been kicked out of the house. There is heavy drinking and drugs. And the young woman has been admitted to the hospital several times for taking an overdose of drugs and heavy drinking.

Peter, age 20, had hung himself in a local jail. He was originally placed in one of our group homes after 10 foster home placements. He was referred due to acting out behaviors. Came from a most unstable family where whenever there was any difficulty they would tell him to get out. He ran away, got into difficulty, and finally was placed with us.

Supportive counseling did help. The family calmed down, messages became more "I care." Finally, after 2 years the young man graduated from high school, left us and went into the Army. That, however, didn't work out and after 1 year he was back home. Things fell apart. There was no supports in the family at that time. Things deteriorated. He began to drift. He got into difficulty and finally ended up in jail where he hung himself, as I stated, during actually his first jail experience and during his first night of incarceration.

So Vernon, Alice, Carol, and Peter are four entirely different individuals, but I think you can see we feel that there are certain threads that run through their lives. They certainly need help since all of them are potentially suicidal. Their problems do not exist in isolation.

We, in our agency, place a very high emphasis on working with the child and the family. We believe the family has to be reached; that if there is a troubled child, there is a troubled family. These families, many of them are very successful and they do not feel that they are troubled, but we believe strongly that it has to be a systems approach. And obviously that involves working with the schools and other community agencies. Many of these families feel isolated. Many are one-parent families or families of divorce. There is just a tremendous sense of hopelessness, helplessness, and no one cares underneath.

Suicidal behaviors are often very indirect, especially the increasing use of drugs and alcohol, and we get many children like that. The risk of suicide in our experience increases with many of these young people when they get out of the support systems and get out on their own. These are the drifting kids that I am quite sure you have heard a lot about—again the aging out population.

Many, many supports are available certainly from our agency for a lot of these young people and their families, but I must say that we must all share in the fact that these supports do not go on and there is a period in time where funding stops and many agencies' services stop, and there is a need to address that.

I would like to come up with some legislative recommendations. I went adrift here more with my own experiences rather than what you have in the written report, but I do want to get back to our recommendations.

One, the Child Welfare League of America and the American Association of Children's Residential Centers recommend passage of legislation creating a specific Federal presence in the area of youth suicide prevention. Due to the dramatic increase in youth suicide rates there is a need for the Federal Government to play a leadership role in research and demonstration programs to identify causes of youth suicide and promising strategies for intervention and prevention. This Federal role should also include developing partnerships with States and local communities to develop successful approaches.

Two, the Child Welfare League of America and the Children's Residential Association recommend that the proposals included in H.R. 1099 and H.R. 1894 are combined into one bill. Both bills have positive provisions which address the issue of youth suicide prevention. H.R. 1099 recognizes the important role local school systems can play and provides resources to facilitate their involvement. H.R. 1894 adopts a more communitywide focus and, more importantly, provides for both short- and long-range planning at the Federal level which is not contained in H.R. 1099. Federal commitment to research and planning is important to carefully take into account the possible influence on suicide contagion that some public education programs have certainly experienced.

In order to facilitate the expeditious passage of this important legislation, the committee might consider using H.R. 1099 as the legislative vehicle since it has been referred to only one committee, whereas H.R. 1894 has been jointly referred.

Three, the Child Welfare League of America and the American Association of Children's Residential Centers recommend that the Secretary of Health and Human Services be given specific responsibility for administering the youth suicide prevention program in cooperation with the Secretary of Education. While the schools can play a vital role in the prevention of youth suicide, the focus on this issue should go beyond the schools and involve the whole community. Here I would like to add that I believe there is no question that schools are the natural start of any prevention program for teen suicide. I believe, however, very strongly that this should be a community effort, should not only be a school effort, and there should be a lot of close working relationships with the public and private sector, the voluntary sector; and I think that there are a lot of good programs in Albany, NY, that work in doing this.

In addition, the programs and research now established by NIMH can provide valuable resources to this nationwide effort and should be coordinated with State and local programs. The Department of Health and Human Services is best equipped to accomplish each of these objectives in cooperation with the Department of Education.

Four, Child Welfare League and the AACRC recommend the establishment of a commission for the study of youth suicide as contained in H.R. 1894.

The Child Welfare League and the AACRC recommend that grant applications not be limited solely to local educational agencies as provided in H.R. 1099 but should also include other community resources.

So, Mr. Chairman, based on these comments I wish to conclude my testimony and certainly will be open to any questions that the committee might have.

Thank you.

[The prepared statement of John W. Carswell follows:]

PREPARED STATEMENT OF JOHN W. CARSWELL, EXECUTIVE DIRECTOR, PARSONS CHILDREN AND FAMILY CENTER, ON BEHALF OF THE CHILD WELFARE LEAGUE OF AMERICA AND THE AMERICAN ASSOCIATION OF CHILDREN'S RESIDENTIAL CENTERS

Mr. Chairman and members of the subcommittee, on behalf of the Child Welfare League of America [CWLA] and the American Association of Children's Residential Centers [AACRC] I am very pleased to appear this morning to respond to the issue of youth suicide and to comment specifically on legislation pending before you. My name is John W. Carswell. I am executive director of Parsons Child and Family Center in Albany, New York and an active member of both organizations. My agency provides residential treatment and outpatient care to emotionally disturbed children and adolescents. I commend the attention you are paying to what is truly a life and death matter for today's youth.

While my purpose this morning is not to talk about the organizations I represent, let me briefly say that both organizations have broad, national memberships composed of professionals and agencies dedicated to the service and treatment of our Nation's children and youth. Both organizations have been around for half a century and have continuously addressed the issue of children's mental and emotional well-being. As professionals, we have noted with concern the dramatic increase in the rate of teen suicide while rates for other age groups have remained constant.

Something is wrong and we appreciate the national focus which the proposed legislation would provide.

INCIDENCE

Some statistics may be helpful. Rates of suicide are reported by the National Center for Health Statistics according to the number of suicides for each 100,000 members of the population in a specific group for a given year. In 1981, the rate of suicide for all people in the United States between the ages of 15 and 24 was 12.3, meaning that of every 100,000 youth, about 12 committed suicide that year (U.S. National Center for Health Statistics). The rate in 1960 was 5.2 per 100,000; the rate in 1950 about 4.1 per 100,000—thus, the rate has increased three times or 300 percent since 1950.

Among young people, males are considerably more at risk and white males most particularly. The rate for white males is 21.1; for black males 11.1; for white females 4.9; and for black females 2.4. Interestingly enough, young women attempt suicide four to eight times more often than young men but young men "succeed" about four times more often.

This year some 6,000 young people will die by their own hand. Between 250,000 and 500,000 will attempt it, depending on various estimates from 1970 to 1978, some 40,000 youngsters died from suicide (National Institute of Mental Health), so that suicide has now become the third leading cause of death for the 15-24-year-old age group.

According to Dr. Larry B. Silver, Deputy Director for Special Projects at the National Institute of Mental Health [NIMH], suicidal behavior in young children should also be given attention. A recent study reported that 3 percent of the 6-to 12-year-olds randomly selected from Westchester County, New York elementary and junior high schools had suicidal thoughts, and 3 percent had made attempts that had not previously been brought to anyone else's attention.

These national statistics tell a disturbing story—a story that has personal consequences. I dare say that each person here has been touched and knows those who have been touched by the reality of youth suicide. As a professional, I assure you that what you hear nationally is a tragic reality in our local communities. An increasing number of the children coming to my agency for treatment have attempted suicide or are considering suicide.

The causes of teen suicide are many and varied. A specific prescription is uncertain. What we do know is that children are faced with increasingly complex life experiences. Pressures exist today which did not exist 30 years ago. More children are victims of child abuse, more run away from home, more have only one parent, more have unwanted pregnancies, more have a dependence on drugs and alcohol, more are depressed. We have found that children experiencing these conditions are particularly susceptable to suicidal behavior. Moreover, a phenomenon known as suicide seemingly triggers other attempts. Our remedies, therefore, must be carefully and deliberately planned and carried out. Emotionally charged public education programs with no thought given to followup could well cost rather than save lives.

LEGISLATIVE RECOMMENDATIONS

1. CWLA and AACRC recommend passage of legislation creating a specific Federal presence in the area of youth suicide prevention.

Due to the dramatic increase in youth suicide rates there is a need for the Federal Government to play a leadership role in research and demonstration programs to identify causes of youth suicide and promising strategies for intervention and prevention. This Federal role should also include developing partnerships with States and local communities to implement approaches found to be successful.

2. CWLA and AACRA recommend that the proposals included in H.R. 1099 and H.R. 1894 age combined into one bill.

Both H.R. 1099 and H.R. 1894 have positive provisions which address the issue of youth suicide prevention. H.R. 1099 recognizes the important role local school systems can play and provides resources to facilitate their involvement. H.R. 1894 adopts a more community-wide focus and more importantly provides for both short- and long-range planning at the Federal level which is not contained in H.R. 1099. Federal commitment to research and planning is important to carefully take into account the possible influence on suicide contagion that some public education programs might have.

In order to facilitate the expedient passage of this important legislation, the committee might consider using H.R. 1099 as the legislative vehicle since it has been referred to only one committee, whereas H.R. 1894 has been jointly referred.

3. CWLA and AACRC recommend that the Secretary of Health and Human Services be given specific responsiblity for administering the Youth Suicide Prevention Program in cooperation with the Secretary of Education.

While the schools can play a vital role in the prevention of youth suicide, the focus on this issue should go beyond the schools and involve the entire community. In addition, the programs and research now established by NIMH can provide valuable resources to this nationwide effort and should be coordinated with State and local programs. The Department of Health and Human Services is best equipped to accomplish each of these objectives in cooperation with the Department of Education.

4. CWLA and AACRC recommend the establishment of a commission for the study of youth suicide as contained in H.R. 1894.

5. CWLA and AACRC recommend that grant applicants not be limited solely to local education agencies as provided in H.R. 1099 but should also include other community resources.

Mr. Chairman, in conclusion, the problem of youth suicide is increasing by critical proportions. It will not go away. Answers are complex and require coordinated leadership from the Federal Government to provide assistance to States and local communities but most of all to the young themselves. Our organizations are committed to improving the lives of children. We look forward to assisting you as you develop this important legislation and encourage timely consideration of these bills.

PROTOCOL FOR SUICIDAL RISK ASSESSMENT

Introduction

This protocol is designed for those children, adolescents, and family members under our care who are suspected of presenting a suicidal risk. The intent is to ascertain the degree of suicidal risk so that appropriate clinical management can be planned. This is done by the team which re-assesses factors that may increase suicidal risk, as follows:

1. FAMILY HISTORY	Yes	No	N/A	Notes
a. loss of parent(s) by death (note if by suicide)				
b. loss of parent(s) by abandonment, separation, divorce, placements, etc.				
c. history of suicide among closer relatives				
d. alcoholism and/or serious drug abuse in parents				
e. history of serious psychiatric illness in parents. Note if chronic depression and psychiatric hospitalization have occurred.				
f. history of persistent suicidal ideation in parent(s)				

SUMMARY OF FAMILY HISTORY:

No Risk Factors ☐
Slight Risk Factors ☐
Moderate Risk Factors ☐
High Risk Factors ☐

2. INDIVIDUAL HISTORY	Yes	No	N/A	Notes
a. loneliness, withdrawal, lack of social/peer relations				
b. serious involvement with alcohol/drugs				
c. chronic boredom, lack of interest for activities				
d. past psychiatric hospitalizations				
e. past suicidal gestures, attempts (note methods used)				
f. past diagnosis of major depression, or psychosis, or borderline personality				
g. history of excessive strivings for accomplishments and experiences of "failure(s)"				

SUMMARY OF INDIVIDUAL HISTORY:

No Risk Factors ☐
Slight Risk Factors ☐
Moderate Risk Factors ☐
High Risk Factors ☐

3. INTENT ("Motivation to die")	Yes	No	N/A	Notes
a. subject consciously acknowledges and expresses wishes to die ("suicidal ideation")				
b. expresses hopelessness and feelings that "there is nothing to live for"				
c. expresses wishes to punish somebody by own death				
d. expresses intense hostility				
e. expresses homicidal thoughts				
f. death is seen as "sleep", "temporary" and reversible				
g. expresses wishes of reunion with dead loved one				
h. clearly sees suicidal gesture as a way to force somebody into certain actions ("manipulation")				

SUMMARY OF INTENT FACTORS:

No Risk Factors ☐
Slight Risk Factors ☐
Moderate Risk Factors ☐
High Risk Factors ☐

4. CURRENT PSYCHIATRIC STATUS	Yes	No	N/A	Notes
a. presence of sad affect, hopelessness, excessive boredom, lack of optimism				
b. unconscious hostility, murderous impulses				
c. dreams featuring death, self or others				
d. poor concentration, loss of appetite, loss of weight, "psychosomatic" complaints				
e. presence of psychotic symptoms, especially self-destructive ideation				
f. current abuse of alcohol/drugs				
g. diagnosis of major depression, borderline personality or psychosis				

SUMMARY OF
PSYCHIATRIC STATUS:

- No Risk Factors ☐
- Slight Risk Factors ☐
- Moderate Risk Factors ☐
- High Risk Factors ☐

5. LIFE SITUATION	Yes	No	N/A	Notes
a. long-standing history of environmental/familial "problems" which more recently have escalated				
b. breakdown of few remaining primary associations ("teen romance" breakdown, move, etc.				
c. social isolation/alienation, lack of interest for social relationships				
d. nobody to turn to, lack of "support systems"				

SUMMARY OF
LIFE SITUATION :

No Risk Factors ☐
Slight Risk Factors ☐
Moderate Risk Factors ☐
High Risk Factors ☐

6. PLAN	Yes	No	N/A	Notes
a. method of accomplishing suicide is highly lethal*				
b. method thought about is available and accessible				
c. plan is very specific in terms of method, time, place, details, etc.				

*The more active, more bizarre the method, the higher the risk. Generally, shotgun and hanging are most lethal, while drug overdose and wrist-cutting are least lethal.

SUMMARY OF PLAN:

No Risk Factors ☐
Slight Risk Factors ☐
Moderate Risk Factors ☐
High Risk Factors ☐

7. IMPORTANT BEHAVIORAL PATTERNS	Yes	No	N/A	Notes
a. frequent accidents, injuries, "near misses" more recently				
b. has left letters, notes, etc. expressing wish to die				
c. there is a suicidal note				
d. sudden change of patterns: school refusal, grades are dropping, doesn't want to see friends, etc.				
e. seems to be leaving a "will"-- i.e. giving away prized possessions, etc.				

SUMMARY OF BEHAVIORAL PATTERNS:

No Risk Factor ☐
Slight Risk Factor ☐
Moderate Risk Factor ☐
High Risk Factor ☐

8. Final clinical judgement: Based on assessment of seven prior areas, it is judged that suicidal risk is:

None ☐
Slight ☐
Moderate ☐
High ☐
Very High & Immediate ☐

9. Intervention Plan (describe):

Chairman HAWKINS. Well, thank you, Mr. Carswell.

Mr. Carswell, which of the agencies mentioned keeps the overall statistics that would be made available to us pertaining to the causes, the demographics on this subject?

Mr. CARSWELL. Are you asking for the report, sir?

Chairman HAWKINS. Is there any center or any one agency responsible for keeping up with statistical information as to suicide among young people?

Ms. Ross, you may know of one.

Mr. CARSWELL. We got a lot of statistics from the U.S. National Center for Health Statistics.

Chairman HAWKINS. That is the one that you rely upon most? Ms. Ross.

Ms. ROSS. Center for Health Statistics has the mortality statistics, so they would have all of the classification of mode of deaths. They can give you the numbers on certified deaths. There are a couple of other national resources for more refined statistics if you want. The Centers for Disease Control, for example, in Atlanta, has some additional statistics, breakdowns of a more sophisticated nature than the Center for Health Statistics.

Chairman HAWKINS. So if we wanted to know who are the ones most prone to suicide, we would rely upon an agency, that agency——

Ms. ROSS. Between them. You can turn to the Center for Health Statistics here in Washington to get some of the raw data. You can turn to the Centers for Disease Control to some more sophisticated studies. And then you can turn to other groups like our Youth Suicide National Center if you want to get, for example, some looks at perhaps college students, your own local community, et cetera. And what we are trying to do at the National Center is pull together different kinds of data to respond to different needs.

Chairman HAWKINS. Thank you.

Mr. Kildee.

Mr. KILDEE. Thank you, Mr. Chairman.

Fred, is a student likely to turn to a school counselor, like your friend, when they have a problem like this? Or how likely might that be or not be?

Mr. WYATT. Well, if they have a favorite teacher. Like he talked to one of our teachers about it after the problem had happened and said, you know, you have any good ideas? If you have a favorite teacher. They usually go to a teacher that knows and is kind to the student; and, you know, she really cares about people and is not one of the teachers who says I don't care if you fail out and stuff like that.

But we had a couple of teachers that he really liked, so he went to his favorite teacher and told her about it. You know, I don't think he would have gone to like the head master or anybody like that because it may get him a bad reputation in school and they may say, you know, watch him.

Mr. KILDEE. The counseling system, or the system itself doesn't provide a good avenue. Maybe it is a special person within that system that they relate to?

Mr. WYATT. Yes, it is more like a special person. It is like if all of them knew about it, then I am sure everyone has a special teacher.

So you know, maybe they could, because I know he has a special teacher and my teacher is different from his, and so on like that. So if I had a problem I would go to a different teacher, too.

Mr. **Kildee**. In real life I was a school teacher, so I think I know what you are speaking about. Before I took this long sabbatical in politics, I was a school teacher.

I guess the over burdened counseling system doesn't really lend itself. The counselors are generally overburdened anyway.

Mr. **Wyatt**. Well, the only counseling that I think does any good is between groups of your peers and your friends. And if you have just like one of them in there. You know, you want to have more friends than you do have counselors because it is hard to stand up one on one with a counselor.

Mr. **Kildee**. You would think any system would be helpful to have, as you mentioned, a system of peer persons would be helpful.

Mr. **Wyatt**. Peer counselor.

Mr. **Kildee**. Thank you very much.

Thank you, Mr. Chairman.

Chairman **Hawkins**. Mr. Fawell.

Mr. **Fawell**. Thank you, Mr. Chairman.

I would like to get back to the rates of suicide again. I have a report here from the Library of Congress, Congressional Research Service, that indicates in the United States in 1981 that the suicide rate was 20.2 per 100,000, Mr. Carswell, I think your statement indicates that it is 12.5, and a report here which I have from the American Psychiatric Association indicates that in the last year there has been a leveling off and downward trend. We get mixed up with statistics quite a bit here in Congress. But the accurate figure is 12.5? If so, I note that we are—insofar as the 15 to 24 age category is concerned generally behind most of the European countries. Not that that is good, bad, or indifferent. But are those the accurate figures? What are the accurate figures I guess I am saying?

Mr. **Carswell**. I assume that from my point of view much of the problem develops out of identifying what group you are talking about where it is an overt attempt at suicide or more indirect. You know there are a lot of people, for example, who get a car up to 100 miles per hour and go into a bridge, you know, and not all those are classified as suicides. But there is a lot more suicide depending on how you look at the statistics.

Mr. **Fawell**. If the figure is 12.5 as, Mr. Carswell, you had in your statement and as the American Psychiatric Association has, then I note that quite a few countries have even more of a severe problem than we have in this country. And yet some of the indications I have had is that we are leading the world and we have more of a severe problem, which perhaps isn't the case.

Ms. **Ross**. My heart goes out to you in your confusion.

Mr. **Fawell**. This is the 15 to 24 age category I am talking about.

Ms. **Ross**. What you have before you and what all of us do is any 10 reports that you gather will probably give you 10 different sets of statistics. I say that not by way of apology but by way of explanation. That it is why effort is needed in this field. We all want to do something about it, and one of the first things that all of us know is to deal effectively with the problem you have to know something accurately about the problem.

First and foremost, if you want to do international comparisons you have to know that almost any study you look at, in this country or abroad, will begin with an opening paragraph that states the statistics are highly unreliable and then proceed to use those unreliable statistics in the article. Internationally what we have are some very strong influences on the reporting system; therefore, countries in which suicide is either an offense legally or to the religion of the country, whatever, show strongly masked figures. Strongly. The common aside in a particular country that does report one of the lowest suicide rates is that you have to have three witnesses to the act in order to get it certified as suicide. That is how much it is covered up. And that means certification has changed.

The numbers here have to do with taking a look at different time periods, different age groups, et cetera. Most of us in the field use the Center for Health Statistics mortality numbers. The others you see are quoted from different studies and then picked up in quotes and picked up in quotes.

There is a tremendous need to clarify those. But I can only tell you that the numbers from the Center for Health Statistics show the 12 and 12.5 depending on what year you are looking at as the recent overall 15- to 24-year-olds. If you will take a look at those numbers, you will see it go up to 17, 18, and 20, and that is looking at adolescent males. That will be looking at your 15- to 24-year-old males at that time, which has one of the highest suicide rates.

I don't know if that helped clarify it.

Let me just throw out one other little aside. I think it is very effective having Freddy answer for himself your question regarding school counselors. You might be interested, because this is a confusing issue, too. Numbers are one, resources are one. In some very large surveys across the country asking youngsters what we considered a very key question: who would they turn to if they were thinking of suicide? I think that is relevant to this legislation. They were given multiple-choice answers: parent, friend, school counselor is one. The bottom of the list was the school counselor. And that does not mean that school counselors aren't effective. What it does mean is that many schools have systems which put the school counselor beyond the reach of most students.

One thing in a recent survey done of a very large number of kids across this country was they were asked who would you turn to within the school system? Because a number of us, including myself, have been working within the schools for 10 years trying to get suicide prevention education approaches as solid as possible. And the youngsters said they didn't care whether it was a counselor, a teacher, a mental health consultant, a social worker—and I have to mention that only about half the schools in this country have social workers. What they did say was if the person was caring, warm—and at the top of their list, trustworthy—trustworthy that they could talk to and that would understand what they were saying and hold it in confidence that was the person. And that is the reason that many of us feel that an entire community, and that means every teacher, every person, and sometimes it is the school janitor. So the people, if we want to save our youth we will educate everyone we can around youngsters.

Had to throw that in.

Mr. **Fawell**. May I have just one question more, Mr. Chairman? Mr. Carswell, you set forth this wording:

> Federal commitment to research and planning is important to carefully take into account the possible influence on suicide contagion that some public education programs might have.

Could you give me a few more words on that? There is a potential that this can occur if we don't do it right, a dissemination of information.

Mr. **Carswell**. Yes; and I am not personally an expert on this particular question. I do know that in one of the local school districts in the Albany, NY, area there was some suicide education that came through and a lot of upset because there was a suicide right after the discussion. So I think that any approach that is needed needs a lot of sensitivity because there are children in the population who are potentially suicidal and they may not be thinking of it today, but they might be thinking of it tomorrow.

I think I would rather have it stressed that whatever is done it should be done with much thought and that there is no easy answer to the problem or to the prevention of it.

Mr. **Fawell**. Thank you.

Chairman **Hawkins**. Mr. Ackerman.

Mr. **Ackerman**. Thank you very much, Mr. Chairman.

Let me commend the panel for their expert testimony and sharing with us their concerns. I would especially like to say to Fred that I want to commend you for your courage and determination to testify before this subcommittee. Despite the fact that some of us up here are pros, we sometimes feel intimidated when we have to do it as well.

And if I can make just one more point to you. It teaches us in the Talmud, which is a Jewish body of learning and wisdom, that to save a single life is as though you have saved the entire world. We would like to tell you how proud we are of you. And with all of our hearings and all of the programs that we are talking about, if we ever get, hopefully, to institute them, with all of the money that will be involved and all of the people that will be involved, if we would be as successful as you were in saving one single life through your act of friendship and love, that we would feel that this entire effort was worth it.

Chairman **Hawkins**. Any further questions from the committee? If not, the Chair would like to thank the witnesses for a very excellent morning of testimony, and particularly to you, Fred, for your appearance before this committee. You come nearest to being one of those that we are discussing—in terms of age group I am talking about now—and we appreciate your participation with these other experts on the subject.

That concludes the hearing. The next hearing of the committee on the subject will be in the city of New York to be announced later.

[Whereupon, at 11:15 a.m., the subcommittee was adjourned, to reconvene subject to the call of the Chair.]

[Additional information submitted for the record follows:]

THE UNIVERSITY OF MICHIGAN-FLINT
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SOCIOLOGY ANTHROPOLOGY SOCIAL WORK

October 17, 1985

Nancy Kober
Legislative Specialist
Subcommittee on Elementary,
Secondary and Vocational
Education
B-346c Rayburn House Office Building
Washington D.C.
20515

Dear Ms. Kober:

Enclosed find two copies of the paper we have developed on teen suicide. We hope the committee can utilize these materials and that they are helpful in your deliberations. Feel free to contact us if you have questions on any of our materials.

Sincerely,

Charles W. Bailey
Charles W. Bailey, M.S.W.
Assistant Professor

R J Kinkel
R. John Kinkel, Ph.D
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SUICIDAL IDEATION IN
SCHOOL-AGE ADOLESCENTS

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October, 1985

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Introduction

Orwell's 1984 predicted shocking social changes for all segments of society. The year has come and gone. For some 5,200 adolescents in the United States it was a year of decision, they chose to commit suicide.

Unfortunately, what happened in 1984 was not unique. In the last three decades the rate of suicide in the 12-18 year-old age group has doubled. During this period our knowledge about youth and suicide has not advanced at the same rate. Previous studies have focused on completed suicides (1) or attempted suicide cases undergoing psychotherapy (2). These approaches, although valuable, are limited due to the small samples they utilize and the validity problems associated with utilizing subjects who agree to therapy and volunteer to cooperate in research projects. Likewise, such endeavors focus on secondary and tertiary prevention, with only modest attention to primary prevention. Few studies of adolescent suicide have examined the youth population precisely to obtain insights about teenage problems and tendencies prior to suicide attempts or completed suicides. Moreover, since "the thought is the father (sic) of the deed", it seems altogether proper to begin to address this burgeoning problem by studying suicide at its inception, namely suicide ideation. To study this topic adequately, we obtained a large random sample of middle school and high school students from Genesee County, Michigan, a moderately large metropolitan area (1980 population = 450,449). Using self-report survey instruments, one of our aims was to determine the nature and extent of suicide ideation in adolescents ages 12-18. This study focused on those factors which tend to contribute to suicide ideation; it is hoped that these findings will be helpful in primary prevention efforts to prevent adolescent suicide. Finally, since suicide ideation is correlated with reported suicide attempts ($r = .41$; $p < .001$), it is clear that the study of suicide ideation has both theoretical and practical implications for mental health professionals (3).

DATA AND METHODS

The study sample consisted of 2676 school age adolescents ages 12-18. Data were collected using multistage cluster sampling (4). In the first stage all middle schools and high schools in the county were listed; a certain number of very small schools had to be dropped from the sampling frame since they had too few students to make a site visit practical. The exclusion of these schools meant that 4% of the students in the county had no chance of being included in the study. A 33 percent sample of schools was drawn from both middle schools and high schools. School officials were asked to be involved in the study; 78 percent of the schools agreed to cooperate in the youth survey project. In the second stage of sampling approximately 100 students from the schools selected were sampled from each group targeted (100 seniors; 100 sophomores; 100 seventh graders). Unfortunately certain school officials objected to items on the youth survey concerned with teen suicide. Thus, our study represents responses from 61% of the targeted schools. After closely examining the type of schools which did not participate in the teen suicide aspect of our survey, we conclude that this study will tend to underestimate the extent of teenage suicide ideation. The schools which declined to partipate were from demographic areas with higher than average rates of drug abuse and delinquency.

On an official school day students were asked to participate in the study with assurances that it was impossible to associate their answers with the questionnaires they handed in since no names or identifiers were used on the survey instruments. A sufficient body of knowledge has been generated to allow us to conclude that self-report methodology produces valid results (5). This cross-sectional research design allowed us to compare those students who reported no suicide ideation (64%) with those who thought of committing suicide at least once in the previous 12 months (33.9%). Moreover, this study was able to examine a number of key factors that previous research has suggested are associated with tendencies to commit suicide.

Data were analyzed statistically by chi-square goodness-of-fit tests, and nonparametric difference of median tests (6). Differences were defined as significant when there was less than 1 chance in 20 that they occurred by chance ($p<.05$).

Results

This study found that 35.9% of the adolescents reported that they had thought of committing suicide at least once in the previous 12 months (Table 1).

A number of factors were found to be associated with adolescent suicide ideation. Like other studies on suicide, these data reveal that females are more likely to experience suicide ideation than males. The student's age proves to be an important factor in understanding suicide ideation (see Figure 1). Students 14 and over have a significantly higher rate of S.I. than those under 14, a difference observed by Albert and Beck (7).

Family background accounts for considerable differences in suicide ideation (S.I.). Our study found, as did Angel's research (8), that family size is related to suicide. Clearly, those from larger families are more at risk. Students with four or more brothers and sisters have significantly higher rates of S.I. than those with less than four siblings.

Students who report that a member of their family currently has a drug problem are more likely to experience S.I. We found, as did McKenry et. al., (9) that negative relations with parents (as measured by number of arguments with parents in previous three months) play a major role in predicting S.I. in adolescents. Although adolescents who come from families disrupted by divorce or separation tend to report higher S.I. pattern, it is evident that negative relations with parents are the single most important family background variable, whether the family is intact or not.

Previous research on the relation of suicide and drug use is only moderately helpful when dealing with S.I. and adolescence (10). Our study revealed that heavy drinking (as measured by number of times respondent had five or more drinks in a row in the previous two weeks) is related to S.I. Use of marijuana on almost a daily basis

Table 1: Differences between adolescents (12-18) with some suicide ideation and those with none on a number of key social factors (in percentages). N = 2676

Variable	Suicide Ideation[a]		X^2(df)	p
	None (n=1671)	At Least Once (n=962)		
A. Demographics:				
Sex				
Male	73	27	109.6(1)	.001
Female	54	46		
Age				
<14	67.8	32.2	44.4(1)	.01
14+	62.3	37.7		
B. Family Background				
Family Size (number of siblings)				
<4	64.8	35.2	5.29(1)	.02
4+	59.7	40.3		
Family history drug problem				
yes	49.9	50.1		
maybe	53.1	46.9	43.7(2)	.001
no	66.9	33.1		
Negative Relations[b] with parents				
yes	46.2	53.8	148.1(1)	.001
no	71.3	28.7		
Divorce/Separation				
yes	57.7	42.3	21.3(1)	.001
no	65.5	34.5		
C. Drug Use by R:[c]				
Heavy Drinker				
yes	35.6	64.4	33.85(1)	.003
no	63.8	36.2		
Daily use marijuana				
yes	58.3	41.7	52(1)	.001
no	63.3	36.7		
Use of amphetamines				
Hi - 3+	36.5	63.5		
Lo - (1-2)	53.7	46.3	116.2(2)	.001
None - 0	65.6	34.4		
Early initiation to drugs				
yes	42.8	57.2	72.83(1)	
no	56.9	43.1		
D. Social Environment				
School success				
yes	63.9	36.1	5.05(1)	.02
no	48.8	51.2		
Experience of child abuse				
Sexual Abuse				
yes	33.3	66.7	82.2(1)	.001
no	64.9	35.1		
Beatings				
yes	38.7	61.3	63.3(1)	.001
no	64.9	35.1		
Exposure to suicide ideation				
yes	43.3	56.7	587.1(1)	.001
no	78.3	21.7		
Life satisfaction[d]	11.6	9.5	17.17	.001

a) Question asked: "During the last twelve months, how many times have you thought of committing suicide?"

b) Had argument with parent(s) every week or more.

c) Had 5 or more drinks in a row in previous 2 weeks on 3 or more occasions. Daily use: means used drug 20 or more times in past 30 days; is "almost" daily use.

d) Median test for significance.

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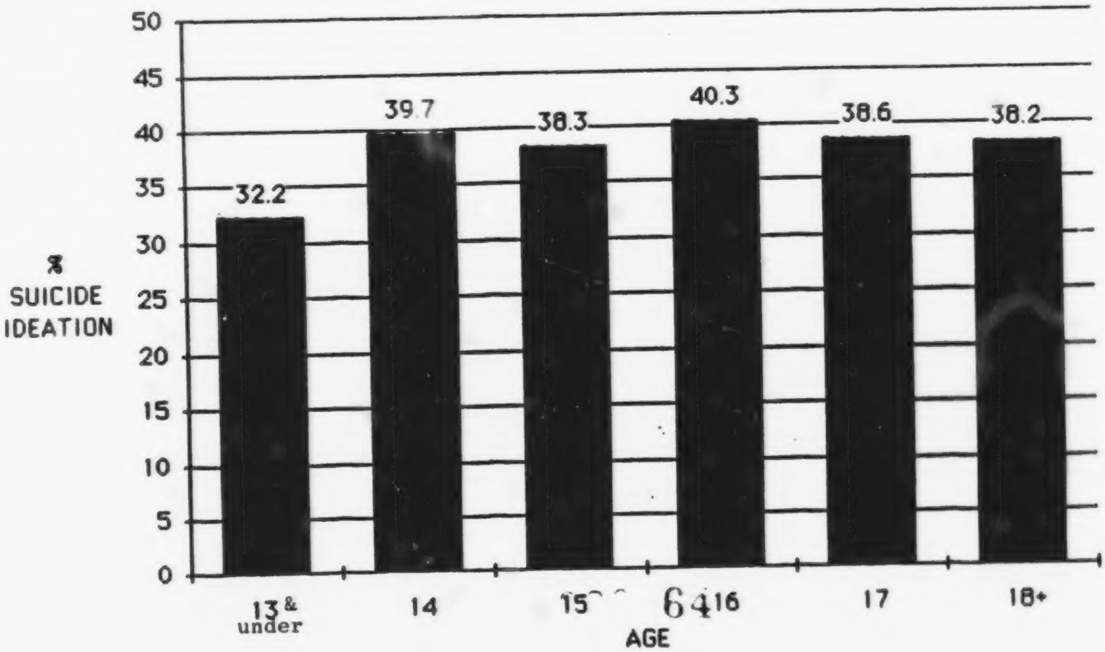
FIGURE 1: PERCENTAGE OF STUDENTS REPORTING 1 OR MORE THOUGHTS OF SUICIDE BY AGE



is likewise associated with S.I. The most important substance use variable related to S.I. in adolescence is daily use of nonprescribed stimulants other than cocaine. These data show that frequent use of stimulant drugs is more important than alcohol or marijuana use in predicting S.I. Finally, we found that the earlier in one's life a person began using drugs, the more likely he/she would experience S.I.

In addition to demographics, family background and drug use, the adolescent's social environment is crucial in understanding S.I. School success as measured by grade point average (GPA) is related to S.I. More specifically, those who report a GPA below the "C" range are much more likely to experience S.I. than those whose GPA is "C" or better. The experience of child abuse, whether one considers sexual abuse or physical beatings, is significantly correlated with higher rates of S.I. Our life satisfaction scale indicates that those who report S.I. are quite unhappy with their overall life situation and presumably quite depressed. Finally, the most important finding of this study relative to S.I. is that those who report experiencing S.I. also report having conversations with others their age about committing suicide in the previous 12 months. This seems to indicate that peer group experiences and exposure to S.I. are crucial in determining an individual's suicide ideation pattern.

DISCUSSION

With the growing concern over escalating suicide rates among adolescents and the paucity of research in the area of prevention, certain findings in this study are of significance for a wide range of intervention programs, but extremely valuable in efforts in primary prevention.

Optimally primary prevention programs for adolescents should involve a host of different resources ranging from physicians and other health care professionals, to mental health professionals, educators, and parents. These programs by definition will work to intervene before a problem occurs or in some cases before a behavior becomes problematic.

The rate of suicide attempts has always been higher among women. Our findings of more frequent suicidal ideation in female adolescents corroborate this observation. The question could be asked: Is the reason for this gender difference a greater sensitivity among females to affect-laden events or to a greater degree of emotional dependence on significant others arising during adolescence? Current research has no clear answers to these questions. Regardless of the reasons for the difference, since suicidal ideation is related to suicide attempts, any revelation of suicidal ideation by the female adolescent should be taken seriously.

Adolescents fourteen years of age and over were found to have more suicidal ideation than those who were a year or more younger. Conceivably, this is explained by the more consistent onset of puberty at age 14, with its attendant physiological and emotional upheaval as well as increasing societal expectations at age 14 than among the 12-13 age group. Nevertheless, the 32.2% incidence of S.I. in this latter group is substantial and should not be overlooked.

The data indicate that not only is substance abuse significant, but the particular drug of abuse is also a critical factor in relation to S.I. Frequent use of stimulant drugs other than cocaine shows the highest relationship to the incidence of S.I. of all the drugs discussed. Though respondents were asked to indicate the incidence of non-prescription amphetamine use, it is doubtful that the majority of adolescents responding to the survey were able to differentiate between any of the various stimulant-type drugs. Undoubtedly a wide range of stimulant drugs were included by respondents in this category, ranging from the amphetamines to the non-prescription substances (caffeine, ephedrine) known as the "look-alike" drugs.

Stimulants may be the adolescent's way of relieving significant feelings of depression and S.I. Since one of the most common symptoms of withdrawal from stimulants is depression, the adolescent is caught in the vicious cycle of continuing to suffer the depression from which he/she was seeking to escape.

Heavy drinking and frequent use of marijuana are also related to S.I. in adolescents, but certainly not as much as the use of stimulants. Early initiation to drug use correlates with S.I. to a higher degree than either heavy drinking or frequent marijuana use. This should be of great concern to primary prevention workers and supports the need for comprehensive services at an early age.

Another important area of concern for those developing intervention programs is the family unit. Professionals should take into account not only the existence of broken homes, but the nature of the relationship that exists between the parent(s) and the adolescent. Although divorce and separation are significant in S.I., the quality of the relationship is of far greater significance.

The data suggest that the area with most significance to S.I. is that of the social environment. School success, the experience of child abuse, satisfaction with one's life, and exposure to S.I. in ascending importance are specific areas of concern for prevention efforts.

Students whose grade point average is below the "C" range experience higher rates of S.I. The exact relationship between school success and S.I. is not clear at this point, but clearly, those who are doing poorly should be given special attention.

The experience of child abuse no doubt contributes to low self esteem and dissatisfaction with one's life. With the current emphasis in targeting child abuse, treatment should include suicide prevention.

The child dissatisfied with his/her life is more likely to experience a whole constellation of destructive life elements. Since adolescents frequently seek out their peers to share experiences, it is not surprising that they talk about their problems, including suicide ideation.

It is unfortunate that these discussions frequently do not lead to fruitful solutions. The exposure to S.I. as measured by the number of times someone has communicated suicidal ideas, is far and away the most significant factor associated with S.I. Understanding this relationship suggests that those professionals who provide prevention services ought to be aware of this and perhaps exercise discretion in raising the issue of suicide particularly if adequate follow-up treatment is not available. Concentrating on a total mental health approach designed to affect the total life situation and to provide adolescents with skills necessary for solving a wide range of life problems seems the most effective approach in primary prevention efforts.

Summary and Recommendations

The multiplicity of significant factors correlated with suicidal ideation among adolescents indicates that the approach to prevention is of necessity, multi-faceted. A cooperative venture between schools and mental health professionals, parents and the community at large is essential. An example of such a venture is the following:

1. Dissemination of information regarding the problem of suicidal ideation and its significant correlates to the community in order to heighten awareness of the problem among parents, teachers, school boards, mental health professionals and the community at large.
2. Development of parent education and discussion groups conducted by mental health professionals with the purpose of orienting the parents to adolescent problems and providing them with effective tools to deal with these problems.
3. Development of discussion groups for adolescents, conducted by mental health professionals to encourage expression of their concerns among their peers and learning appropriate ways of dealing with change and events in their daily lives which may be confusing or frightening.
4. Facilitating meetings between these groups which address mutual concerns.
5. Allocation of funds for these activities and programs by school and mental health boards as well as by local and federal funding agencies.
6. Continued research on adolescent suicide in order to assist prevention programs.

These are very tentative steps toward addressing a wide-ranging problem, but provide a necessary beginning. A life directed away from self-annihilation is a life turned toward greater productivity and fulfillment.

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YOUTH SUICIDE PREVENTION ACT OF 1985

MONDAY, OCTOBER 21, 1985

House of Representatives,
Subcommittee on Elementary, Secondary, and
Vocational Education,
Committee on Education and Labor,
Yonkers, NY.

The subcommittee met, pursuant to call, at 10:20 a.m., at the Hudson River Museum, 511 Warburton Avenue, Yonkers, NY.

Members present: Representatives Biaggi (presiding), Ackerman, DioGuardi, and Owens.

Staff present: Nancy Koher, legislative specialist and Andrew Hartman, Republican legislative associate.

Mr. Biaggi. The meeting is called to order. I am pleased to convene today's hearing of the House Education and Labor Committee to examine the appropriate Federal role in order to combat youth suicide. I want to thank the Family Service Society of Yonkers, Jim Feldman, executive director, for hosting today's event. This hearing is the first congressional hearing held in Yonkers since I began representing the 19th Congressional District in Congress. Today's hearing represents the second in a series of national hearings our committee is conducting on this profound and distressing national tragedy. We are specifically looking for the appropriate Federal role in helping to combat this problem. We are on the heels of a growing problem, begging a multitude of strategies for a solution. Consider these facts: It is estimated that 6,000 young people will commit suicide this year and another 280,000 will try it. The United States is the eighth-most suicidal nation in the world. Since 1960 the rate of suicide for youths age 15 to 24 has tripled. According to Secretary of Health and Human Services Margaret Heckler, a young person commits suicide every 90 minutes. Suicide is the eighth leading cause of death in the United States. It is the third leading cause of death among adolescents and the second among college and university students. The committee has chosen to come to Westchester because we know there is a significant problem here. This year, there have been five incidents in the first part of the year which nearly equals all of last year's totals. We are not here to glamorize or glorify the problem. We are here because we know there are a number of effective community-based strategies that are being used to attack this problem head on. We will hear from a number of people who will provide the committee with an understanding of how we can best meet community needs and also to hear what more can be done. Two approaches are found in two bills we will review today. H.R. 1099, authored by our colleague, Gary Ackerman, who is here today, which will provide $10 million for school-based prevention programs; and H.R. 1894, Youth Suicide Prevention Act, which would authorize $6 million for prevention activities within communities and by States as well as establish a national commission to examine the problem. As a cosponsor of both these measures, I believe our primary responsibility at the Federal level should be to direct additional funds to this prevention effort. This year, we are spending $850,000 nationally to research this problem, of which $381,000 is for New York. We are spending only $664,000 for prevention activities, of which $150,000 has been allocated to New York. I suggest to you that less than $2 million is a small piece of change to attack a significant national problem. Passage of legislation to directly address this issue will assist us in the effort to spend a little more in order to get a lot more in return. I look forward to today's testimony and thank the witnesses in advance for their comments and for their information. Before I call upon my colleagues for their comments, I would like to read a letter I received from the parent of a young man who committed suicide in Florida, Garrett Wolmsley is the father. "Enclosed is the newspaper summary of the ordeal our family suffered. Obviously we are still in a state of shock, but we want to help those who are in a similar plight. Today a lot of attention is focused upon the parents being aware of warning signs from their children for possible drug use and suicidal depression. We felt our Kevin was in need of help. We turned to the school system, medical profession, counselors, mental health center, and finally to the legal system, all to no avail, because no one cared to thoroughly test, examine, and to sit down with Kevin and find his problem. Do you care that a healthy 16-year-old boy who should have been making happy teenage memories committed suicide? What can we do to help others? Respectfully, Garrett Wolmsley, father."

Mr. BIAGGI. Mr. Ackerman.

STATEMENT OF GARY ACKERMAN

Mr. ACKERMAN. Thank you very much, Chairman Biaggi. You have my deep appreciation and gratitude of millions of American families for conducting this, the second round of hearings on a modern American tragedy, teenage suicide. I would also like to thank you for joining with me in introducing H.R. 1099, the Suicide Prevention Act.

This measure now carries the names of 33 cosponsors. Other Members of Congress have joined in our crusade, our colleague, Tom Lantos of California, Mr. DioGuardi of Westchester County have also been very active in this mission.

Our breakthrough legislation would create a small grant program with the Department of Education. The Secretary would select proposals from local educational agencies to design, organize, and operate suicide prevention programs. This bill, if enacted, would authorize the grants for 3 years under an annual cap of $10 million. No group or school board could receive more than $100,000 in any 1 year. The programs that would be developed, with the help of this legislation, would reflect the valuable input of parents and community leaders as well as that of mental health professionals and school personnel.

This approach, then, takes the talents and expertise of all segments of the education and youth service field and focuses on the important task of saving lives of America's kids.

Mr. Biaggi, during the first day of hearings in September, the Subcommittee on Elementary, Secondary, and Vocational Education witnesses expressed their strong belief that suicide prevention programs should reflect the community's dedication to opening communication lines with young people in order to relieve the stress that so often precipitates a suicide attempt.

For too many years, discussions of suicide have been relegated to hushed, almost silent tones. Unfortunately, we have not let our children understand that the problems they perceive as insurmountable really do have solutions.

For the most part, there has been no Federal commitment anywhere in our Nation to stop teen suicide. Some schools have improvised programs, but these random efforts have usually come too late, only after the loss of a young life.

One individual who testified before the subcommittee this summer was a shining light within the dark and gloomy subject. Fred Wyatt sat at a table and recounted his courageous and heroic act of saving the life of one of his dearest friends. He brought a sense of hope to those who may be skeptical of our children's ability to help each other.

Today we will hear different strategies and stories about the suicide epidemic. This is a plague that knows no boundary. A troubled child stays behind no borders. Geography, education level, income, ethnicity, religion, gender, social status, none of these is a limit on teenage suicide. This plague can strike a youngster in Scarsdale as easily, quickly, and fatefully as it hits a child in Harlem. Teenage suicide is a national problem and cries out for a national response.

H.R. 1099, by saving children and by sparing families excruciating agony responds to a void which the Federal Government can and should help to fill.

Mr. Chairman, any loss of life is tragic. The loss of a child is devastating. The self-inflicted death of a young one is an unthinkable horror yet think about it we must, so that we can understand it and prevent it.

Thank you, Mr. Chairman.

Mr. BIAGGI. Thank you.

Mr. Owens.

Mr. OWENS. Mr. Chairman. I have no statement at this time.

Mr. BIAGGI. I note the arrival of a colleague, Mr. DioGuardi. Why don't you join us.

Mr. DIOGUARDI. Thank you.

Mr. BIAGGI. Mr. DioGuardi.

STATEMENT OF JOSEPH DioGUARDI

Mr. DIOGUARDI. I came prepared to give some testimony. Congressman Ackerman and I have testified at least one hearing at the House.

It is a pleasure being here with such distinguished Members of the House, Congressman Biaggi. Thank you for taking the issue here. It is an issue we are very much concerned about in Westchester County. We've had a problem for the last few years, an unfortunate problem in that we are amongst the highest, if not the highest county in the country on this particular issue.

I commend Congressman Ackerman on his leadership in this issue.

I am pleased to be here this morning to discuss what I have come to believe is a major and growing problem in our country, a problem yet to be completely understood and recognized, the problem of teen suicide. I think it is well known now that the suicide rate in this country has remained level, but the teenage component has increased dramatically.

I understand it has doubled.

We are all here today because we care about our young people. Young people are under much pressure in contemporary society and are forced to grow up very quickly. Obviously, today's kids are growing up in a world vastly more complex than the world we grew up in a generation ago. Today very early in life, young people are forced to take responsibility and proceed with their lives, sometimes before they are emotionally capable of doing so.

This is not to say early responsibility is a bad thing. But, unfortunately, some cannot cope. I think this is really what we are looking at. The experts feel the pressures come out in many ways and one of them is the ultimate step that some of these kids take.

As a U.S. Representative, and as a father of two children just entering their early teens, I am concerned what the institution of Congress can do and should do to first understand then help alleviate the problem of young people taking their lives.

My district, the 20th Congressional District in Westchester County, approximately two-thirds of the county, is clearly a cluster zone for teen suicides. Unfortunately, in the last 18 months close to 20 young people took their lives.

Even more painful and intimidating is the fact, and I have heard statistics, that for every successful completion of this ultimate act, at least 100 additional attempts are made and never reported and, of course, among those, some of these young children then maim themselves in the process.

We have a great many young people in need of our help. I believe the Federal Government has a role to play in this mission.

U.S. Senator Jeremiah Denton and I introduced legislation that designated June "Youth Suicide Prevention Month." We were able to garner the required cosponsers in the House for passage and President Reagan signed the bill into law in late May. This was a good means of publicizing the need for more public awareness of the issue, but it is only the beginning of what must be done. Representative Lantos of California and the gentleman from New York, Mr. Ackerman, both have excellent teen suicide preventive legislation pending in the House of Representatives. I applaud them and Congressman Biaggi for their leadership and expertise in this area. I fully support the thrust of their legislation and as cosponsors of both, hope we can all work together to secure passage to secure Federal funds.

It will not be easy considering the physical climate in Washington, but hard work on our part can make a difference.

The superb work of Alfred DelBello and Charlotte Ross of the Youth Suicide National Center in Washington, DC, have prompted me to become involved with lending my background as a certified public accountant and business manager to the effort of teen suicide prevention. I believe if we can secure Federal funding, we must treat every dollar as a scarce commodity, which they are these days, and spend them as efficiently as possible. We must maximize every resource we have.

One area I am extremely interested in exploring is the notion of diversifying our resource base so as to aggressively pursue funding from private sector sources.

I was heavily involved in fund raising activity for charities like the Phoenix House, Boy Scouts of America, organizations that have made major contributions to our society. There is much we can do to get the private sector involved in this area and I am currently studying the means of doing so.

The Federal Government is an ideal place to acquire the seed money for national commission and grants for funding independent legislation. But I believe the exploration of private sector funding source is essential to any long-term effort to stem the growing and frightening problem of young people taking their lives.

In closing my remarks, Mr. Chairman, I want to say that teen suicide prevention is not a partisan issue. It is an issue we all can get together on and rally around because the greatest resource we have in this country is our youth and our youth need our help. This is not a Democratic issue nor a Republican issue. It is a human issue that demands our response as Federal legislators. I believe that together we have the tools to make an effective and lasting mark against a problem so painful to us all. Thank you, Mr. Chairman.

Mr. BIAGGI. Thank you.

The first panel consists of Stephen J. Friedman, deputy commissioner, Westchester County Department of Community Mental Health; Alfred DelBello, an old friend, chairman of the National Community of Youth Suicide Prevention; George Cohen, human relations specialist, White Plains School District, White Plains, N.Y, representing the American Association for Counseling and Development; and Beth Corney, White Plains School District.

Mr. DelBello.

STATEMENTS OF ALFRED DelBELLO, CHAIRMAN OF NATIONAL COMMUNITY OF YOUTH SUICIDE PREVENTION; STEPHEN J. FRIEDMAN, DEPUTY COMMISSIONER, WESTCHESTER COUNTY DEPARTMENT OF COMMUNITY MENTAL HEALTH; GEORGE COHEN, HUMAN RELATIONS SPECIALIST ON BEHALF OF AMERICAN ASSOCIATION FOR COUNSELING AND DEVELOPMENT; AND BETH CORNEY, PEER LEADER, WHITE PLAINS SCHOOL DISTRICT, A PANEL

Mr. DELBELLO. Thank you, Mr. Chairman, Congressmen Owens, DioGuardi, Mr. Ackerman, thank you very much for being here today.

I appreciate the opportunity for going first, because I am going to have to leave a little after 11. But I would like to stay as long as I can to participate in the discussions and to hear the comments.

I thank you and I congratulate all of you and other members of Congress who have seen fit to get involved in this suicide prevention issue for our young people which is so critical to our Nation today. I prepared remarks, but I am not going to use them. I would rather be a little reactive.

Mr. **Biaggi**. If you will, please, we will have your prepared remarks included in the record.

Mr. **DelBello**. Thank you.

Let me talk freely and reactively to some of the things happening today, comments that are made, directions in which I think we ought to be going.

It was 2 years ago or maybe a little sooner that no one really talked about youth suicide. It was happening, it was going on, the statistics were there. It was one of those topics kept in the closet and nobody dared mention it for fear that they couldn't handle the problem and for greater fear that it would be embarrassing to the family, school district, community, so it was covered up.

It was determined back then that it was an issue that had to be made public, that had to be brought to the fore because if it was not there would be no one to deal with it. It was getting worse, dimensionally worse with every day that passed. So, it was intentionally made a public issue in order to attract public support, legislative support within the State and within the Congress.

What is happening historically now is I believe we are at a point in time where everybody is interested. They now understand the dimensions of the problem and want to do something about it.

This is an extremely critical point because the next few steps that are taken are going to determine whether we can succeed in combating this problem or whether we just exacerbate the situation or frustrate the situation.

What I mean by that, simply, is, we know we have a problem. I dare say we do not know the dimensions of the problem. Congressman Dio Guardi says, according to certain statistics, for every actual suicide among young people, there is 100 more attempts. I say there is 50 more attempts. Not because you are smarter or I am, just I use one report and you use another report. I will say it is way over 6,000 young people each year killing themselves. One of you miqht say there is 6,000, another might say there is under 6. The fact is, we really do not know how many kids killed themselves last year. We really do not. We do not know how many kids intentionally took their own lives.

I would say we know how many striped bass in the Hudson River would be affected by Westway, down to every single one. We probably know how many frogs died in a pond over here in Westchester County. We know how many deer there are in the fields. I mean, we know statistics, and I do not mean to degrade that. That is good. We are interested in what is happening around us. Except we have not made an effort to even know statistically exactly what is happening with our children.

Now, that might sound impossible to believe, but I think I can verify the fact that we really have not gone into single occupant car accidents to find out if we can detect how many are intentional or accidental. We really have not gone into the overdose situation to see if we can develop a methodology for determining whether the overdose was accidental or intentional. In so many cases of apparent accidental deaths, we do not know how many are actual suicides.

The first point I want to make is that with the publicity, with the attention, with the concern now we ought to at least get our hands on the problem. There ought to be a dedicated national effort to understand statistically and in depth exactly what is happening.

The Federal Government is making attempts through the Atlanta-based center for disease control to work up statistics more accurately, get a better reporting system and that should be applauded. But I believe we need a much greater attention and much greater emphasis. If we are going to do anything, we better know exactly what our problem is, at least statistically. At least statistically.

The second thing I am concerned about is that we do not just attempt to throw money at this problem, because I am convinced we are not going to cure it with money. I am convinced that the nature of the problem is so far more complex, so deep, so involved in our own society, so involved in the socioeconomic aspects of our society that to think it is something we can research for a little while, develop a drug or innoculation and apply it and the problem will go away, I think is badly misunderstanding the depth and complexity of what we are dealing with.

I believe what we need is to set up a couple of activities at the same time. Certainly, we need short-term immediate action which would be in the form of whatever counseling, whatever therapeutic kinds of activity, whatever educational activity we can induce, and which also would involve immediate intervention in the case of a problematic child or situation that looks dangerous.

I am recommending very strongly that we create a national hotline. Let me tell you why. Not only because everybody and their brother has an 800 number today, it is not that big a deal. The U.S. Air Force has one, the U.S. Senate has one. My own company has an 800 number. If you want to call our company, you just have to call 800 and you can get us.

It is not a difficult thing to set up. Its cost is directly related to its use. I think if a child or somebody were to call for help, we would be happy to pay the few dollars that that phone call costs us.

But the reason I am suggesting it is, as we have established our national committee, we are now organized in 46 out of the 50 States. We are represented on committees or what we call chapters in 46 States. One of the dramatic things appearing from this action is that every State is so different. Some have fairly comprehensive mental health systems, others have very sporadic mental health systems. Some have programs within the schools that are very well developed, other States do not. I can see a young person or parent in one of these States turning for help and not knowing where to go because there is nobody nearby. A national hotline, which is computer based, could have people to answer the phone who could very easily refer phone calls for people who need help to the nearest available help. You do not try to counsel them on the phone, but just try to get them to somebody quickly. That would help. It is an intercession, a way of reacting quickly.

I believe schools have to do what they can to develop programs. There are some programs being developed today that seem to be of some benefit. I think our mental health systems, as you will hear from Westchester County, are getting more tuned in on doing more and that should be encouraged.

That is short-termed. That should be aid. Whatever money Congress wants to put out to help in that area would be greatly appreciated.

But the area where I am most concerned is that we undertake a process of research and investigation to understand our children and to understand what is underlying this terrible tragedy, what is causing this tragedy to increase in its dimension and proportions. That research is going to be very complex. It is not a laboratory situation where we can fund some research lab someplace and expect the results in a year or two. It is going to mean we are going to have to ask of ourselves as parents and adults, ask of our society, we are going to have to ask of our institutions, religious and secular, some questions which could be very embarrassing to us. But if we do not ask the questions, do not get the true answers, we are never going to understand the kind of environment that exists today that induces children to kill themselves.

The dichotomy that exists is almost tragic. We have never produced in the entire history of the world a group of young people more educated, more involved, more intelligent, healthier than we have today. Yet, we never have experienced in the history of our own country, at least, a group of young people more bent on destroying themselves with drugs, alcoholism, and suicide than we have.

In paradox, that dichotomy is what is going to have to be dealt with.

We have recommended as a national committee that a national committee on youth suicide prevention be created, very similar to what is being recommended in the Lantos bill. The purpose for that is really threefold. One is, through the national commission, we can create a national focus. We bring the nations together by the representatives on the commission, by the hearings that are held, by the activities of that commission, so that in a way we can galvanize the nation behind one issue.

It can also be the focal point for requiring adequate statistics be produced, because obviously that commission is going to need statistics if they are going to be able to demonstrate inadequacy of a lot of these statistics.

That commission can also require that appropriate professional and indepth research be undertaken by institutions and scholastic institutions and scientific institutions that are adequate to research this problem with Federal support, which I think is very important.

Those purposes alone justify the creation of a commission, in my mind. I do not know another way of approaching it where you get this interdimensional effect across the country. If there is another way, I would certainly support it.

The moneys that are put out, as I say, today, could be looked at fairly critically by the Federal Government. We know that today in Washington there is not an attitude to create another social program. We know that the Federal Government is not anxious to go out and create another program that could run into tens of millions of dollars; that if we lead certain people in Washington to believe that that is what is going to be required to cure this problem or deal with the problem—that is a misnomer to say cure—what we are really going to do is ask for defeat or at least stalemate of these issues as we move through Congress. I think it would be much better to say if we had a national commission that did not require any money, just the staff money to get it going, created a national focus and did some endowing of institutions that were adequate to get into this in depth, and if we did want to support the Federal money and not tie the two together, the grant money and research, because I would hate to see the research effort defeated by the people who say we are not going to put a dime out for any proposed social program today.

Again, I compliment you for your efforts. It is very badly needed. Our organization, the National Committee on Youth Suicide Prevention, is working to have a chapter in every State. We are working very hard to raise money to support worthwhile programs because we do believe there should be a significant amount of voluntary effort involved. This should not be an issue left to Government. It really is not Government's issue in that sense. It is really a local societal kind of problem that the community has to respond to. So, we are trying to cause that to happen through the raising of money, the participation of volunteers. We would ultimately like to see a permanent foundation funded in this country to deal with adolescent problems.

We have foundations or institutions studying just about everything in the United States except our children. There is not one single permanent institution established to understand what our own children are going through decade to decade, generation to generation. Our ultimate goal is to fund the foundation on a permanent basis to accomplish that.

Again, I thank you very much for the time you are giving to all of us and particularly for the time you are devoting yourself to this issue.

[The prepared statement of Alfred B. DelBello follows:]

PREPARED STATEMENT OF ALFRED B. DELBELLO, CHAIRMAN, NATIONAL COMMITTEE ON YOUTH SUICIDE PREVENTION

BILLY JOEL IS ONE OF THE MOST POPULAR RECORDING ARTISTS IN THE UNITED STATES. LIKE MOST SUCCESSFUL PEOPLE, HE CARES DEEPLY ABOUT THE QUALITY OF HIS WORK. SO WHEN HE STUTTERED SLIGHTLY WHILE RECORDING "YOU'RE ONLY HUMAN/SECOND WIND" ONE OF HIS MOST RECENT RELEASES, HE WANTED TO RERECORD THE SONG.

BUT THEN HE CONSIDERED THAT THE SONG -- INSPIRED BY MEDIA COVERAGE OF SUICIDE -- IS MEANT TO ENCOURAGE PEOPLE WHO HAVE MADE MISTAKES -- AND MAY BE CONSIDERING SUICIDE -- TO GIVE THEMSELVES ANOTHER CHANCE. AND THE ERROR REMAINED UNCORRECTED.

BILLY JOEL HAS A SPECIAL EMPATHY FOR YOUNG PEOPLE WHO ARE CONSIDERING SUICIDE. HE ONCE DID HIMSELF. AND EACH YEAR, SOME SIX THOUSAND YOUNG AMERICANS BETWEEN THE AGES OF FIFTEEN AND TWENTY-FOUR DO KILL THEMSELVES. THAT FIGURE REPRESENTS A LOSS OF LIFE THAT EXCEEDS THE AVERAGE ANNUAL CASUALTY RATE OF THE VIETNAM WAR!!!

NO ONE KNOWS HOW MANY OTHER YOUNG PEOPLE TRY TO END THEIR LIVES. BUT THE AMERICAN ASSOCIATION OF SUICIDOLOGY INDICATES THAT THERE MAY BE AS MANY AS FIFTY UNSUCCESSFUL ATTEMPTS FOR EVERY ACTUAL DEATH. AND THE CENTER FOR DISEASE CONTROL - IN ATLANTA - HAS ESTIMATED THAT AS MANY AS TWO MILLION FIFTEEN TO NINETEEN YEAR OLDS TRY TO KILL THEMSELVES EVERY YEAR. OF THOSE WHO SURVIVE, MANY WILL TRY AGAIN. AND MANY OF THEM WILL DIE.

THOSE CHILLING STATISTICS TELL ONLY PART OF THE STORY. DURING THE PAST THIRTY YEARS, MEDICAL ADVANCES HAVE REDUCED MORTALITY RATES FOR EVERY SEGMENT OF SOCIETY EXCEPT ONE: YOUNG PEOPLE BETWEEN THE AGES OF FIFTEEN AND TWENTY-FOUR. MORTALITY RATES FOR THIS AGE GROUP HAVE SKYROCKETED. THAT'S BECAUSE AN APPALLING AND UNPRECEDENTED NUMBER OF THESE YOUNG PEOPLE -- TORMENTED BY SEEMINGLY IRREVERSIBLE, INTERMINABLE FEELINGS OF HOPELESSNESS, HELPLESSNESS, INDIFFERENCE, AND DESPAIR -- ARE CHOOSING TO END THEIR PAIN BY ENDING THEIR LIVES. THE HARSH REALITY IS THAT SUICIDE

AMONG OUR NATION'S YOUNG PEOPLE HAS NEARLY TRIPLED SINCE 1950! SUICIDE IS THE FASTEST-GROWING CAUSE OF DEATH AMONG PEOPLE BETWEEN THE AGES OF FIFTEEN AND TWENTY-FOUR. IN ADDITION, MANY ACCIDENTS MAY ACTUALLY BE UNRECOGNIZED OR UNACKNOWLEDGED SUICIDES.

SOMEWHERE IN THE UNITED STATES, AN UNKNOWN NUMBER OF YOUNG MEN AND WOMEN ARE PLANNING TO KILL THEMSELVES TODAY. STATISTICS BASED ON BITTER EXPERIENCE TELL US THAT ONE WILL DIE EVERY NINETY MINUTES.

TODAY'S SOCIETY IS AT ONCE PRODUCING THE BRIGHTEST, MOST INFORMED, YET MOST SELF-DESTRUCTIVE YOUTH IN THE HISTORY OF MANKIND.

A RECENT STUDY FOUND THAT BY THE TIME THEY GRADUATE FROM HIGH SCHOOL, FULLY FIFTY PERCENT OF AMERICA'S YOUNG PEOPLE HAVE SERIOUSLY CONSIDERED KILLING THEMSELVES. AND SOME

EXPERTS BELIEVE THAT AS MANY AS ONE OF EVERY TEN STUDENTS HAS ACTUALLY PLANNED HIS OR HER OWN DEATH.

YET DESPITE THESE OVERWHELMING STATISTICS, WE DO NOT UNDERSTAND WHY THOUSANDS OF YOUTHS EACH YEAR CHOOSE DEATH OVER LIFE AS A SOLUTION TO THEIR PROBLEMS. SOCIETY MUST BEGIN TO UNCOVER THE POORLY UNDERSTOOD FORCES -- FAMILY DYNAMICS, SHIFTING SYSTEMS OF VALUES, INCREASED PERSONAL FREEDOM AND RESPONSIBILITY — UNDERLYING THIS TRAGEDY.

AND THERE IS AN UNDENIABLE NEED FOR MORE NUMEROUS, MORE EFFECTIVE SUICIDE PREVENTION PROGRAMS. WE CAN'T ALWAYS ISOLATE THE CIRCUMSTANCES THAT LED A YOUNG PERSON TO COMMIT THAT FINAL, FATAL ACT. BUT WE CAN USUALLY RECOGNIZE A SUICIDAL STATE OF MIND. AND WE'VE DEVELOPED SYMPATHETIC, HIGHLY SUCCESSFUL COUNSELING TECHNIQUES DESIGNED TO HELP DISTRAUGHT YOUNG PEOPLE RECOGNIZE THEIR PROBLEMS, REALIZE THAT DEATH IS NOT THE ANSWER, AND HELP THEM TO REBUILD THEIR LIVES.

THAT'S WHY THE NATIONAL COMMITTEE ON YOUTH SUICIDE PREVENTION WAS ESTABLISHED. A VOLUNTARY NATIONWIDE NETWORK OF CONCERNED, COMMITTED PARENTS, PROFESSIONALS, AND SOCIAL WORKERS, THE NATIONAL COMMITTEE ON YOUTH SUICIDE PREVENTION IS DEDICATED TO REDUCING THE NUMBER OF ACTUAL AND ATTEMPTED SUICIDES AMONG OUR NATION'S YOUTH BY ESTABLISHING, FUNDING, AND SUPPORTING PROGRAMS FOR YOUTH SUICIDE PREVENTION.

OUR IMMEDIATE GOAL IS TO ACQUIRE THE NECESSARY FUNDS AND DEVELOP THE RESOURCES NECESSARY TO:

- o INCREASE PUBLIC AWARENESS OF YOUTH SUICIDE,
- o PUBLICIZE THE WARNING SIGNALS THAT PRECEDE ATTEMPTED SUICIDE,
- o ENCOURAGE THE DEVELOPMENT AND SUPPORT THE IMPLEMENTATION OF YOUTH SUICIDE PREVENTION PROGRAMS,
- o ESTABLISH A NATIONAL INFORMATION AND REFERRAL SYSTEM,
- o ACQUIRE, ORGANIZE, AND DISSEMINATE CURRENT INFORMATION ON SUICIDE,
- o SEEK TO ESTABLISH A FEDERAL COMMISSION ON YOUTH SUICIDE

PREVENTION,

- SUPPORT RESEARCH ON SUICIDE,
- SPONSOR AND SUPPORT INTERDISCIPLINARY PROFESSIONAL CONFERENCES,
- PROVIDE COORDINATION FOR AND ASSISTANCE TO ORGANIZATIONS WITH SIMILAR GOALS,
- AND CREATE A FOUNDATION TO FUND YOUTH SUICIDE PREVENTION PROGRAMS SELECTED BY THE NATIONAL COMMITTEE.

THE DEPTH OF THIS PROBLEM GOES BEYOND THE VOLUNTEER SECTORS ABILITY TO HANDLE. THE FEDERAL GOVERNMENT, THROUGH THE CONGRESS, CAN PLAY A ROLE. LEGISLATION IS NECESSARY FOR THE ESTABLISHMENT OF A FEDERAL COMMISSION WHOSE PURPOSE WOULD BE TO:

- PULL TOGETHER AND ELEVATE FEDERAL EFFORTS
- DEVELOP AN ACCURATE AND EXHAUSTIVE NATIONAL DATA BASE
- RESEARCH AND ANALYZE THE CAUSES OF YOUTH SUICIDE

- o FORMULATE POLICY DIRECTIONS FOR THE FEDERAL GOVERNMENT
- o PROVIDE ASSISTANCE AND MODEL PROGRAMS TO STATE AND LOCAL GOVERNMENTS

IN ADDITON, THE PRIORITIES OF THE FEDERAL GOVERNMENT MUST BE REFOCUSED. ALTHOUGH MASSIVE EXISTING MENTAL HEALTH AND EDUCATIONAL RESOURCES EXIST, ONLY $1.7 MILLION A YEAR IS SPENT ON THE THIRD LEADING CAUSE OF DEATH FOR ADOLESCENTS - SUICIDE.

AS CONGRESS CONSIDERS ACTION ON YOUTH SUICIDE, WE URGE YOU TO CONSIDER A BALANCED LEGISLATIVE APPROACH — ONE WHICH INCLUDES PROVISIONS FOR BOTH IMMEDIATE INTERVENTION PROGRAMS, AND LONG-TERM RESEARCH AND ANALYSIS INTO THE ROOT CAUSES OF THIS SERIOUS PROBLEM.

THE FACT STILL REMAINS THAT WHILE THE CONGRESS IS DEBATING LEGISLATION, WHILE MODEL PROGRAMS ARE BEING DEVELOPED, WHILE RESEARCH IS CONDUCTED, YOUNG PEOPLE CONTINUE TO TAKE THERE OWN LIVES. PREVENTION REQUIRES IMMEDIATE ACTION THROUGH THE ESTABLISHMENT OF A NATION-WIDE YOUTH SUICIDE PREVENTION HOTLINE. MANY AREAS OF THIS COUNTRY ARE WITHOUT THIS KIND OF SERVICE WHILE FEDERALLY FUNDED TOLL FREE NUMBERS EXIST FOR EVERYTHING FROM INFORMATION ON TAX FORMS FROM THE IRS, TO RECRUITMENT INFORMATION FROM THE AIRFORCE IN DENVER, TO SENATORS' OFFICES. FURTHERMORE, PRIVATE OR NON-PROFIT HOTLINES EXIST TO ORDER LUGGAGE, MAGAZINES, RECORDS AND INFORMATION ON COCAINE ADDICTION. BUT THERE IS NO CENTRALIZED, RELIABLE NUMBER THAT A YOUNG PERSON CAN CALL IN A TIME OF STRESS OR EMOTIONAL CRISIS. THE ESTABLISHMENT OF SUCH A HOTLINE COULD MEAN THAT THOUSANDS OF YOUNG LIVES WOULD BE SAVED FROM UNNECESSARY TRAGEDY.

BY AND LARGE, AMERICA HAS IGNORED THE ANGUISH OF HER YOUNG PEOPLE. WE AS A SOCIETY, CAN NO LONGER AFFORD TO LOSE THESE YOUNG PEOPLE. WE MUST LOOK BEYOND THE STATISTICS...SEE THE PROBLEM IN TERMS OF HUMAN LIVES... ENVISION THE SOLUTION...AND WORK TOGETHER TO IMPLEMENT IT.

THE NATIONAL COMMITTEE ON YOUTH SUICIDE PREVENTION WILL CONTINUE TO WORK TO REDUCE THE ALARMING INCIDENCE OF SUICIDE AMONG YOUNG PEOPLE. BILLY JOEL HAS JOINED THE EFFORT THROUGH THE DONATION OF ROYALTIES FROM HIS SONG TO THE COMMITTEE. THE CORPORATE SECTOR, THROUGH SIGNAL ENVIRONMENTAL SYSTEMS, HAS DONATED MONEY AND OFFICE SPACE. BUT YOUTH SUICIDE IS A NATIONAL PROBLEM WHICH CUTS ACROSS RELIGIOUS,SOCIAL AND ECONOMIC BACKGROUNDS, AND OUR FEDERAL RESOURCES MUST BE BROUGHT TO BEAR ON IT.

BRITISH ESSAYIST CYRIL CONNOLLY HAS WRITTEN: "THERE IS NO SUICIDE FOR WHICH ALL SOCIETY IS NOT RESPONSIBLE." IT IS AN AWESOME RESPONSIBILITY. BUT IT IS ONE THAT WE DARE NOT DECLINE TO ACCEPT. WE HOPE THE CONGRESS WILL JOIN IN OUR PREVENTION EFFORTS.

Mr. **Biaggi**. Thank you.

In deference to your leaving at 11 o'clock, I think the members may have comments and questions, so, why don't we address Mr. DelBello's comments before we go on to the other witnesses.

With relation to an endowment, I think it is an excellent idea. I am not as pessimistic about the ability to get some $10 million. If that is all we are talking about, in a budget that runs into hundreds and hundreds of billions of dollars, a trillion, it is important to get started. I think the establishment of a national commission is critical. It can be supplemented later by the formation of a foundation. But clearly, you have a moving force, coalescing all the efforts.

Some of the suggestions you made were excellent, really. A national hotline. You are right. It is not a big thing any more, not even innovative. But it is a place where people can reach out. It is important to have someone out there to respond and direct and give some help in one fashion or another.

As far as research is concerned, Mr. Ackerman's bill, which we have cosponsored, clearly provides money for research. That is critical. Speaking from a practical perspective, as I am sure you know as a former executive in Government, you always need that money to staff and get things underway.

Again, back to the foundation notion, whatever information is obtained, whatever progress is made through the Government effort can really be transmitted to a foundation once we get underway. I think that notion is one we will pursue, the formation of a foundation.

What I think is very important, however, and you said it clearly, is statistics that are accurate. No one really knows. I have been through that with crime and—no one really knows. That becomes justification for a course of action.

But I recall the experience we had with child abuse many years ago. When I first came to the Congress, I involved myself with child abuse when no one was speaking to it. Of course, when I was a police officer, I saw it. But the full magnitude did not come home to roost until I became associated with Dr. Vincent Fontana, a paragon of effort and knowledge in the area.

One of the principal problems is no one reported it. People did not want to get involved. Teachers did not report, hospitals did not report, doctors did not report and police did not report. The result was, in that area, we passed mandatory reporting laws. Suddenly we saw the full magnitude of the problem skyrocket to the forefront. You see it every day. It did not happen overnight. That took a decade or so of activity.

Assessing the magnitude of this problem is critical. I think you make the point well.

In your statement you detailed the work each of those 46 States do in their variations? Do you do that in your statement?

Mr. **DelBello**. We will put in as much as we can.

Mr. **Biaggi**. That is important to see. Communities get involved. In the end, I believe, it is principally a local problem. It has to be dealt with by the professionals, every aspect of it, starting with the young folks. I am glad we have Beth Corney who will testify today. Young folks and parents associations and community groups and the professionals must deal with it. I think that we all work together in the researching aspect of it.

Mr. **DELBELLO.** Let me indicate one thing that has been coming out as a result of setting up these State chapters and some of the research we have been doing, and the reason why I think a national hotline is required.

There is a bad misunderstanding of where youth suicide occurs. This is not Westchester's problem. It is not New York City's problem. It is a rural problem. I shock people when I show them the statistics. When I was Lieutenant Governor, I did an indepth research project on the counties of the State of New York. Highest suicide rate in New York is Green County. Second highest, Yates County. Rural counties. The urban areas have the lowest rate of youth suicide. When you look nationally, the highest incidence statewide in the country, I could be wrong, it is either Wisconsin, South Dakota, or North Dakota. Rural States. Agricultural States. It is a phenomenon so badly misunderstood.

As you dealt with it, county by county, you realize a county sitting back without mental health structures are the ones that need it more than anybody else.

Communities like New York City that are very sophisticated in mental health systems do not have the problem as much as they do in rural areas. That is why you need national focus and national attention and some national dimension on the problem. I wanted to add that fact.

Mr. **BIAGGI.** A salient fact.

Mr. Ackerman.

Mr. **ACKERMAN.** I just want to congratulate Al DelBello on his wonderful presentation. It was certainly very, very enlightening. I also want to congratulate him on his very early leadership in this area, as our Lieutenant Governor and as the president of the Senate. I had the pleasure to serve under your leadership, in this as well as in other areas. It is absolutely spectacular. Those of us who are still in elected public life have been done a great service by your showing the commitment, not just because we are elected public officials, but because it carries over into our lives as private citizens, especially an issue as important as this one.

I would like to make one comment so there is no confusion between the two bills that have been introduced, one by myself and one by Congressman Lantos. His bill calls for a national conference. Mine does not. We are both supportive of each other's legislation, and I am wholly and completely in support of a national type of conference and meeting.

The reason I have not put that in my particular bill is absolutely and purely pragmatic. That is, because with the commission in the legislation, the bill must be referred to two committees. The committee other than the one that Mr. Biaggi is chairing right now, we do not believe, would be as favorable to reporting the bill out expeditiously as will the Committee on Education and Labor.

So, rather than let the bill die because it will not be reported by the second committee, I have chosen to eliminate the conference at this point from my legislation. But I think the conference is an absolutely marvelous idea.

Mr. BIAGGI. I might comment, that is a very, very strategic move. Referring the bill to the Education and Labor Committee, of which I am ranking New York member, virtually assures its being reported out.

Mr. DELBELLO. I was not aware of that. That is good to know.

Mr. ACKERMAN. Thank you.

Mr. BIAGGI. Mr. DioGuardi.

Mr. DIOGUARDI. I appreciate your testimony, Al. I am only in office, you know, 10 months. And your name has come up many times. I was confused in the beginning why Al DelBello's name keeps coming up on this issue of teen suicide. It is only in the last few months I realized you are continuing the efforts you started.

I guess as county executive here in the county, you have a lot of friends that keep reminding me of that good work. Hopefully we can continue to work with you.

I spent the bulk of my professional life involved in the community with youth. I was 7 years on the board of Phoenix House. I had to resign that position to run for office. Three years on the board of Boy Scouts, Boystown of Italy. I have been concerned. Having two sons myself approaching teens, I have been concerned.

I have to go back to the Phoenix House model. We have a young psychiatrist, Rich Rosenthal. He took the city drug program and made it into a national program because he surrounded it with a board of interested citizens, people with influence in the community. Now close to half of the funding is from private sources in this program. When you look at the program, it does the very thing that is needed here. You are talking about suicide and youth suicide. That is not the problem. That is a symptom. We are talking about a symptom. The real problem is what is affecting the youth of this country. It is the same problem that affects them when they go on to substance abuse. That is one step along the way of considering suicide. It is the ultimate step when someone decides to take his or her life.

You are talking about a symptom here of a much greater problem that we have to understand as, Al, you have pointed out. There is no doubt we have to take this issue out of the closet, but very delicately. Obviously, in drawing attention to it too much, you may tend to educate some kids to this being an alternative for them. We have to be very careful as to how this is handled.

I am not a psychologist or psychiatrist. Obviously, we have to look to them to help build a model that is going to work.

When I look at Phoenix House and saw what they did, they never treated the drug problem. When you come to Phoenix House, the drug problem is incidental. They look at the individual and look at the individual in terms of restoring an individual's self-confidence, self-respect, esteem, through communication, inter-community, group encounter, single encounter, getting the parents involved, getting the teachers involved. All of a sudden, this individual becomes aware that there are caring people, that they are not isolated. You know what happens? Not only does the drug problem go away, but all problems go away. You have to see the graduates from Phoenix House. I am sure there are other drug rehabilitation programs—how they take their place in society with confidence. Unbelievable.

One of the most amazing experiences I had was the graduate corner. Before a board meeting a graduate would come and talk before the presidents of General Foods and a 19-year-old would walk in with no intimidation and address the board saying how they were in such desperate need and how they are now back into society.

The point I want to make is we have to look at the private sector alternatives. Al, you are talking about it. I understand you have a foundation, you already have something being funded. There is the answer. There is the answer in general for society's program, to look for government to seed money, but to get the private sector back involved where it should be on the issue.

Thank you for your good work, Al.

Mr. **Biaggi**. Mr. Owens.

Mr. **Owens**. I also want to congratulate you on your efforts to date. You mentioned one surprise that you discovered in respect to suicide being a rural phenomenon that most people do not realize. I wondered if you also discovered or can corroborate some information that came out in the past week or so where Margaret Heckler reported on black health problems in the country. One of the things pointed out is that the suicide rate among young blacks was high.

I also talked to some black professionals on the weekend and they said it is on the increase. I wondered if you uncovered any further facts and evidence in your exploration.

Mr. **DelBello**. I really do not have any hard information at all on what the breakdown is between black, white and how it is moving. I have seen numbers, but I really do not know for sure what is happening in those areas. All we really know are general reporting kind of data that has been put into the computer State by State, county by county. I doubt if anybody really has a hard handle on what is happening between white, black, Hispanic, the different cultural backgrounds. I don't really know myself the statistics.

Mr. **Owens**. What comes through is that American youth are much more monolithic than general beliefs and the causes of despair are many, not limited to middle income, middle class or white populations. It is a phenomen in low income and all the various ethnic groups.

Thank you very much.

Mr. **Biaggi**. Thank you, Mr. Owens.

I want to thank you once again, Al, for your presentation and your testimony. As usual, as throughout your entire career, you have always done an excellent job. We need you in government, but I am sure you are happy where you are.

Mr. **DelBello**. Thank you.

Mr. **Biaggi**. Mr. Friedman.

Mr. **Friedman**. I am Stephen Friedman, Deputy Commissioner of Westchester County, Department of Community Health. I would like to welcome you, Chairman Biaggi, Congressman Ackerman, Congressman DioGuardi, Congressman Owens. Westchester County is the fifth largest government in the United States and 33d largest county in the United States. It has a firm tradition of responsive mental health services. New York State was the first State government to respond with community mental health services legislation.

Westchester County was the first county in the country to establish a community mental health board to begin joint governmental, private funding of local community mental health services.

By the 1980's, we had a very large county and voluntary sector system of mental health services. We intend to address the problem of adolescent suicide in many different ways.

I will begin reading from my testimony at this point.

The Department of Community Mental Health and its contract agencies have initiated various programs to address the issue of teenage depression and suicide. For the past 13 years, the number of teenage suicides in Westchester County has stayed largely constant at five to six per year. This rate of suicide is less than the rate for upstate New York and less than the national rate. In 1983 the suicide rate for adolescents was 3.8 per 100,000 for Westchester County; for upstate New York it was 4.1. National rate has consistently run 5 per 100,000.

Westchester by its urban-suburban nature, its rural nature, supports much of what Al said of the rates of suicide being differentiated by urban, surburban, and rural areas. However, you get a concomitant increase in adolescent homicide rates in urban areas. You may have a reporting phenomenon or a cultural phenomenon where individuals because of cultural taboos are unable to commit suicide, but will precipitate a homicide of themselves. You have dramatically different homicide-suicide rates from urban to rural areas and from black to white adolescents.

There are significantly different reporting levels at this point where the rates of suicide for 10 to 19-year-olds are dramatically higher males to females, dramatically higher white, blacks to black. White males tend to run statistically reporting of about 3 to 4 per hundred thousand. White males, as you reach 17, 18, 19 level are closer to 20 per hundred thousand.

There is a dramatic difference whether you deal with the reported statistics of a white male in a suburban rural area or black female in an urban area. This is something that needs further evaluation of studies. If you look at existing statistics, there are dramatic differences which geography, size of municipal government and by race of individuals.

We have focused in Westchester on five areas: services, education, public information, general mental health promotion, and prevention activities, and research.

In services there is a 24-hour hotline in the county, staffed normally during the week by the Mental Health Association of the county; nights, evenings and weekends, available around the clock by New York Hospital and St. Vincent's Hospital, two private psychiatric facilities. The hotline was started in 1968. It's been available since then, and handled 5,400 calls during 1983.

The Student Assistance Program began in six schools in 1979. During the academic year 1984–85, this school-based program was in 30 high schools and three middle or junior high schools in the county. It identifies and assists students who may have school, family, peer, alcohol, drug or other personal problems. Counselors who are masters level social workers or psychologists speak at PTA and other community groups on problems affecting adolescents.

In 1980, my department, Department of Community Mental Health, and the Westchester County Medical Center developed what we call the Family Support Program to assist families of suicide victims in Westchester County. There is some correlation between suicide of parents and suicide of siblings with increased rates of suicide. It is now expanded to include families in which a member died suddenly from any cause. Upon notification from the medical examiner's office of a sudden or unexpected death, such as a car accident, suicide, fire or whatever, a letter is sent by our department to the family offering crisis counseling. By December of last year, we had contacted 95 individual families and either personally or through continued telephone consultation done service work with about a third.

The Committee on Sudden Adolescent Death [COSAD], in this county was formed in 1984. It provides education, guidance and support to school personnel who must deal with a student suicide or sudden death. The committee is a cooperative effort among schools, the department, the Interagency Task Force on Adolescent Depression and Suicide and private psychiatric hospitals. Two major conferences have been held on the issue of adolescent suicide through COSAD.

Westchester County Medical Center Mobile Crisis Service began operation in 1979 and along with Rockland Psychiatric Center crisis teams, a major state facility, provides 24-hour crisis services to our whole community. Resources are now provided by two state psychiatric hospitals, Peekskill Community, New Rochelle and the county's Department of Community Mental Health.

The crisis service currently treats those 28 years of age and older with continued discussions of what was essentially diverted from existing children's programs to providing this kind of crisis response to individuals less than the age of 18.

Initially, crisis services tend to be developed for those 18 and above, mobile crisis capability is largely needed when you have individuals who, because of their own pathology or reclusive nature are unable to be brought to emergency room services to respond. Often children under the age of 18, there is a family or school situation that can begin to bring this person to treatment. We are still trying to make the basic decisions as to whether or not one transfers large amounts of resources in order to run a 24-hour, 365-day team. You understand you need five staff lines to provide one person in round-the-clock work. If one would have this kind of dramatic team for adolescents, covering social work, psychologists and psychiatrists, it is a major division of resources. We are making these decisions.

Right now the crisis services serves those 18 and above.

Through December of 1984, approximately 246 individuals were seen each month. This is a dramatic increase as the team has been established at approximately 185 the year before, rising in geometric fashion.

Therapy and counseling services are widely available throughout our community by our various contract agencies and facilities.

Besides direct services, groups for families or friends of suicide victims are conducted by clinicians at Westchester Jewish Community Services and at the Mental Health Association.

Those are our direct service programs through the mental health system of services, another very important, very specific part of efforts which I will touch on briefly. George Cohen will address it more so. This is what we call the Interagency Task Force on Adolescent Depression and Suicide.

It was formed in 1979 to study the proper response to what then, in the middle and late 1970's was actually a similar, if not higher, rate of suicide than occurred in Westchester in 1984-85. Our rate actually peaked 1978, 1979, and then went down. Now it is beginning to turn back up. It was formed in 1979 in response to suicide primarily, then, in Chappaqua and Scarsdale. They conducted sessions for students, school personnel and community audiences on identification, treatment of teenage depression and suicide, training parents in recognizing signs of depression, teaches students how to respond if a friend talks about suicide and publicizes community resources.

In 1982 my departmental staff surveyed all Westchester County school districts to elicit information regarding what services were available and what service gaps existed so appropriate programs could be developed. This led to dramatic increase in task force activities.

In 1984, 134 presentations by the task force occurred, reaching an audience of 8,000 persons, 28 separate school districts were addressed by the task force.

Workshops have been conducted on this issue by county government, medical college and many of our local educational facilities. We have had some very strong public service announcements supported by the county executive. Both the county executive and commissioner of public health have spoken on television shows discussing the danger signs of teen suicide and information has been printed and widely distributed through agencies and schools.

Besides this, we place a great deal of emphasis of primary prevention services of groups we believe to be at considerable risk. We are struck by the correlations between prior suicide attempts, prior completed suicides within families and siblings, of a strong relationship between chronic severe alcoholism and drug abuse, both within family settings and within the individual. Also we have major interest in research.

Westchester County, through my department, participates in a major study of completed or attempted suicides. It is funded by the National Institute of Mental Health, directed by Dr. Shaffer, a man I believe to be the preeminent clinical epidemiologist in his field.

In spite of all of these efforts, all of which existed prior to 1984, we come to the issue I think brings the committee to Westchester and brought some prominence to the county. In a 6-week period during February and March of 1984, Westchester County had four adolescent suicides, a neighboring county, Putnam, had an additional suicide. There was a sixth individual incorrectly reported throughout the media as an adolescent suicide. We had a clustering effect, which is another issue that at this point needs significant research and epidemiologic examination. There is a phenomenon of clustering within adolescent suicides where one death appears to trigger additional deaths and as the qeneral taboos and general proscriptions against suicide are removed by the committed suicide of another child within that geography, it appears to be some triggering event to the next child who prior to this had been thinking about it, had been fantasizing about it and then understands and realizes, often through media coverage, that this event can occur, that it can go from thought to an actual occurrence.

There is the danger that heavy reporting will in some cases describe actual methodology, so children learn of methodologies involving certain pills as opposed to others, involving firearms.

There is an additional phenomenon that we wonder about some of the clustering that is unfortunate and in some ways an unnecessary event to many families, the reporting after a suicide often involving discussions with family and friends tends to be sentimental, romanticized, cleansed version of a child's life. Very necessary as part of their bereavement, as part of their understanding of the event, but often incorrect, cleansed information that can be very frightening to other members of the community and to other parents when they hear of a child who supposedly had no symptomology of a child not depressed, of a child who because of a very harmless adolescent incident, failure to make a school team, end of a relationship with a boyfriend or girlfriend, failure of an exam, poor PSAT or SAT grades, that this became the precipitating factor. Incorrect information.

It is another problem with a lot of the reporting and discussion of the issue. You get what is necessary to friends and families to say, and remember, their bereavement needs to heighten what was positive in the relationship. They do not need to be reminded they have missed a warning sign or that others may have failed to break the silence when one child discusses it with another.

As we reviewed the legislation, we strongly are in favor of increased funding for epidemiological research, clinical research in this area, the causation is not well understood. We are dealing with individuals who are 10 to 19 with a phenomenon rate 5 per hundred thousand. It is low. It is dramatically less than that for white males over the age of 60. Major suicide rates in this country happen to be senior citizens. Much higher rates. It is a different kind of phenomenon and a phenomenon maybe more understood. You need at this point dramatic research and dramatic epidemiological looking. When you get in six per hundred thousand, there are few cases from which you can draw information.

[Material submitted by Stephen J. Friedman follows:]

SERVICES IN WESTCHESTER COUNTY
RELATED TO
ADOLESCENT DEPRESSION AND SUICIDE

Background

The Department of Community Mental Health and its contract agencies have initiated various programs to address the issue of teenage depression and suicide. For the past 13 years, the number of teenage suicides has remained stable, an average of about 5 per year. According to official N.Y.S. Department of Health figures, the teenage suicide rate for Westchester County has been lower since 1980 than national and upstate New York figures. In 1983, the suicide rate for adolescents was 3.8 per 100,000 in Westchester County. For upstate New York it was 4.1 per 100,000. The national rate has consistently run at 5 per 100,000.

We have focused on five areas: services, education, public information, general mental health promotion and prevention activities, and research.

I. Services

- There is a twenty-four hour crisis hotline staffed by the Mental Health Association weekdays and by St. Vincent's Hospital and New York Hospital evenings and weekends. The hotline was started in 1968 and handled 5,400 calls during 1983.

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- The Student Assistance Program began in [illegible] schools in 1979. During the academic year 1984-85, this school-based program will be in thirty high schools and five middle or junior high schools. The program identifies and assists students who may have school, family, peer, alcohol, drug or other personal problems. Counselors who are masters level social workers or psychologists have spoken at school assemblies, PTA's and other community groups on the problems affecting adolescents.

- In 1980, the Department and the Medical Examiner developed the Family Support Program to assist families of suicide victims in Westchester County. The program has expanded to include families in which a member has died suddenly from any cause. Upon notification from the Medical Examiner's office of a sudden or unexpected death (such as a car accident or a suicide), a letter is sent from a Community Service Center Administrator offering crisis counseling. Family members of suicide victims, especially siblings, are at risk of suicide or depression. By December, 95 families had been contacted during 1984.

- The Committee on Sudden Adolescent Death (COSAD), formed in 1984, provides education, guidance and support to school personnel who must deal with a student's suicide or sudden death. The Committee is a cooperative effort among schools, the Department, the Interagency Task Force on Adolescent Depression and Suicide and Four Winds Hospital, a private psychiatric hospital. Two major conferences have been held in 1984, focusing on prevention, intervention and response within the Westchester school system.

- The Westchester County Medical Center Mobile Crisis Service began operation in 1979 and along with the Rockland Psychiatric Center Crisis teams in the southern part of Westchester, provides service to the whole County. Resources are provided by Harlem Valley and Rockland Psychiatric Centers, New Rochelle Hospital, Peekskill Community Hospital, and the Department of Community Mental Health. The New York State Office of Mental Health also provides Community Support System funding. The Crisis Service currently treats those 18 years of age and older, although younger people have been seen on occasion. We are attempting to obtain funds to expand these services to include those under 18. Crisis Teams, which include psychiatrists, psychologists, social workers and nurses, operate 24 hours a day throughout Westchester with the main location at the Medical Center and supplementary service at the two auxiliary sites in Peekskill and New Rochelle. Through October, 1984, approximately 246 individuals were seen each month. In comparison, 188 individuals were seen per month during 1983.

Therapy and counseling services are widely available to children, adolescents and families through our Community Service Centers, our contract agencies, the State facilities and the private hospitals and practitioners. Westchester County has one of the most extensive system of services in the country.

Currently, groups for families or friends of suicide victims are conducted by clinicians at Westchester Jewish Community Services and at the Mental Health Association.

II. Education

- In 1979, an Interagency Task Force on Adolescent Depression and Suicide was formed to study the problem in response to student suicides and attempts in Westchester, primarily in Chappaqua, Buchanan and Scarsdale. Committee members of this Task Force, which now operates under the auspices of the Mental Health Association, conduct sessions for students, school personnel, and community audiences on identification and treatment of teenage depression and suicide. Specifically, the program assists parents, students and educators in recognizing the signs of depression; teaches students how to respond if a friend talks about suicide; and publicizes community resources. In 1982, DCMH staff surveyed all Westchester County school districts to elicit information regarding what services were available and what service gaps existed so that appropriate programming could be developed. One example of such responsiveness is increased Task Force activity in the schools. By the end of December, 1984, 134 presentations had been scheduled for audiences totaling about 8,000 persons. Twenty-eight school districts had been reached.

- Workshops have been conducted by Department staff, the Mental Health Association, New York Medical College and others for school administrators, guidance counselors, teachers and mental health clinicians focusing on warning signs, resources, intervention techniques, crisis intervention and suicide prevention.

- Educational workshops are being planned for emergency room staff to help them properly handle psychiatric problems and to identify potential victims so that appropriate referrals for further mental health service can be made. In addition these workshops will be given to police and ambulance personnel.

III. Public Information

- Public service announcements have been recorded by County Executive O'Rourke. Both the County Executive and the Commissioner of Community Mental Health have spoken on many radio and television shows heightening awareness of suicide, informing people of the danger signs of the depressed adolescent and discussing the many resources available in Westchester.

- The Department's Coordinator of Community Education has arranged numerous speakers for professional groups, communities and parents on the subject.

- A list of warning signs and emergency numbers for five geographic areas in the County has been printed and widely distributed.

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IV. General Mental Health Promotion and Prevention Activities

- Emphasis is placed on efforts to strengthen the ability of people to cope with stressful situations in their lives so that the probability of suicide as a final resort is reduced. Programs have been developed for high risk groups within the community.

V. Research

- Westchester County, through the Department, participates in a major study of completed and/or attempted adolescent suicides. This project, funded by the National Institute of Mental Health, is directed by Dr. David Shaffer, Professor of Clinical Psychiatry and Pediatrics, Columbia University, College of Physicians and Surgeons, an international authority in the field.

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Mr. **Biaggi**. Clearly, research is necessary. I would like to pick up on what you said with respect to the methodology. This committee is sensitive to that area and we are fearful of the copycat syndrome. We have studiously avoided going into any of those areas. We are just talking about the more general, lofty, and professional approach. We are aware of the danger.

Mr. **Friedman**. It is service issues. We believe service and prevention efforts should be targeted to adolescents in a more general way than primary suicide prevention to adolescents chronically involved in drugs, with suicide patterns in the family and who are chronically depressed. Some of the more broad-based efforts have been reviewed by Miller in the Journal of Public Health, showing little efficacy of freestanding suicide prevention activities except with white females under the age of 24, a group, however, with one of the lowest suicide rates.

Review of a major primary prevention activity of the Samaritans, a major English study, have shown there are other ways of beginning to look at reducing levels of suicide. England found that two of the sociologic phenomena that could be addressed that had some of the strongest effects, first, a change in prescription practices, in which there is a major change that you do not prescribe sedatives, barbiturates with lethal potential, but much less toxic forms. England found an ability to specifically change suicide rates by changing the form of domestic gas from a toxic to nonlethal form. These kinds of societal approaches were very effective in other countries and need to be further examined in our own. Thank you.

Mr. **Biaggi**. Mr. Cohen.

Mr. **Cohen**. Good morning, Mr. Chairman and members of the committee. My name is George Cohen. I am a human relations specialist with the White Plains School District and former chair of the Interagency Task Force on Adolescent Depression and Suicide in Westchester County. I appreciate the opportunity to share with the committee my concerns about this very important topic.

I speak to you today on behalf of the American Association for Counseling and Development, an organization comprised of more than 46,000 professional counselors who work in the areas of education, mental health, rehabilitation and human services. I might also add that the American School Counselor Association, a division of AACD is the largest organized body of its type in the world.

Sitting next to me is Ms. Beth Corney, a peer leader. Peer leaders are carefully selected and well-trained students who work with other students to help them with a variety of problems. You will be hearing from Beth in a few minutes.

Mr. Chairman and members of the committee, let me first express my appreciation for the work you are doing and to encourage your support of legislation which seeks to prevent the tragedy of youth suicide. In Westchester County alone we have had approximately six suicides each year of students between the ages of 13 and 19. In my role with the Westchester County Interagency Task Force on Adolescent Depression and Suicide and as a human relations specialist, I have found that although this statistic has remained quite constant, the number of suicide attempts has increased dramatically. Unless we take strong, active steps, we may see a dramatic rise in completed suicide.

While various communities throughout our Nation are attempting to deal with these suicides, it is both timely and critical that the Federal Government support these efforts by making available resources which many local communities are unable to provide. A national effort toward understanding and actively working to prevent youth suicide is certainly appropriate.

I am asking Congress to meet the challenge of investing in our Nation's youth through enactment of legislation to help coordinate various programs aimed at preventing youth suicide. We are encouraged with hearings conducted on H.R. 1099 and 1894. Our association was pleased that in the two pieces of legislation were the inclusion of grants to provide training to those who constantly deal with the problems experienced by a young person.

It is the professional counselor who will oftentimes find themselves at the frontline of a crisis situation involving an adolescent. While many counselors and other school and community personnel may be able to react to the problems faced by our Nation's youth, how satisfying it would be to know that we took a proactive, preventive stance which diffused a potentially dramatic and tragic incident.

Regardless of what some people may believe about the stereotypical role of the school counselor, it is a profession which finds itself facing the tasks of addressing a student's concerns over family relationships, drug and alcohol abuse and other factors which may force the individual to consider taking his or her own life.

Youth suicide cuts across all racial, ethnic, and financial lines. While we may not be able to divert all attempts of youth suicide, we can and must begin to train those most closely associated with young people so they may conduct classroom prevention programs, train peer counselors and develop appropriate identification and intervention programs for high-risk students.

Counselors, school administrators, social workers and members of the community must have adequate training in knowing what to look and listen for in a potential suicide victim.

For some the training has taken place and the programs are operational. However, in the vast numbers of communities in this country, woefully inadequate resources are available for such programs.

Both H.R. 1099 and H.R. 1894 are positive steps in assisting communities facing youth suicide.

Westchester is fortunate in that it has prevention programs in grades 5 through 12. However, funds are needed to conduct training programs for school personnel, purchase material, provide support and follow-up services to the schools, and to encourage effective school practices that will reduce the number of both completed and attempted suicides.

To improve upon the legislation proposed in Congress, we offer the following suggestions.

In H.R. 1894, while we strongly support the establishment of a commission to study the causes of youth suicide, and prepare short and long range recommendations, we feel that the commission would be strengthened if, in title I, section 104, members were selected from names submitted by the American Association for Counseling and Development. The reasoning for this is that professional counselors, especially those in education and mental health, really are at the frontline of crisis situations.

Also, in title II, section 203, subsection (b), we understand the need to fund programs with a proven "track record," but feel that this section would prohibit needed programs in those areas which do not currently have an operation in place. We recommend an amendment to this section which would allow new programs an opportunity to apply for grants.

In H.R. 1099, we support the language which mandates that grants under this legislation be used to supplement and not replace State and local funds. We would recommend that in addition to local education agencies, that those community programs which receive State and local funds also be eligible for grants.

The members of our association stand ready to assist you in whatever way possible and urge you and your colleagues to support H.R. 1099 and H.R. 1894. These two bills are long overdue.

Thank you.

Ms. **Corney**. Good morning, Mr. Chairman, members of the Committee. My name is Beth Corney. I am a senior at White Plains High School. Since suicide has become a major problem in Westchester County, there are now programs to help students like myself help others. The program that taught me how to work with people and their problems was peer leaders at White Plains High School. Thanks to this program I saved a life.

It was during the summer at the beach in New Jersey when this incident occurred. I was working in a clothing store with others my own age and since we worked the same hours, we all grew very close. But it was Larry to whom I grew the closest.

Larry seemed cheerful most of the time, but after I got to know him I realized his bright smile was just an act. This was just a coverup so his true feelings wouldn't show. It was after he knew he could trust me, when he decided to confide in me.

His father had died 2 years ago and since then his life has been crumbling. His mother is now an alcoholic, his grades prevented him from going to college and his older brothers and sisters just don't care.

We would discuss his problems during our lunch break and it seemed that his problems became less of a burden for just an hour. After lunch thoughts of his home situation would return and depression would again set in. I had worked with him and followed the technique that I learned at peer leaders and each day he told me he felt better.

It was almost a week after I had spoken to Larry that I had my own problem to face. My father had suffered a heart attack and was admitted to a hospital in Newark, NJ. This meant I would be alone for a few days while my family roomed at the hospital.

The ear-piercing ring of the telephone was what dragged me out of bed one night. The words that came through the receiver left me speechless. "I am going to kill myself," seemed to repeat in my mind over and over again. I soon realized this was my scared and confused friend, Larry.

After I collected my thoughts, I quickly remembered the listening procedure for a possible suicide victim. Larry agreed to meet me on the boardwalk that night.

Shivering on a bench, I saw him approach me in the dark. He had been crying and his eyes were red and puffy. I knew this was no prank.

I could understand what he was going through. Besides his girlfriend problems, his biggest fear was what comes next in life. His mother spent money on alcohol and the family income was low. Since he could not get into college, his dreams of being a psychiatrist were shattered.

After an hour of talking, we came to some conclusions. I persuaded him to enroll in a community college and take a couple of psychology classes. If he can handle it, then he could take it from there and work his way toward a degree. We also discussed his talking to a counselor or psychologist. He agreed to speak to his mother about her drinking problem and even persuade her to join an Alcoholics Anonymous group.

Larry has rejected the idea of committing suicide. He realized that not only were there people who care about him, but life holds new opportunities for him to face.

I am proud of the fact I helped save Larry's life and I owe it to peer leaders. The program includes juniors and seniors in high school and we learn how to help others with problems. During the 15-week period we share feelings, ideas and problems while learning the major steps in becoming a successful peer leader. But a small organization cannot help every one. That is why we need government support.

With the money that could be provided, teenagers with problems now have a chance to talk about them instead of taking the easy way out. The future generation are the teenagers of today. Without your support, where will we be tomorrow?

Thank you.

Mr. BIAGGI. Thank you, Beth, for your work in the peer group. I think the choice of you as peer leader justifies the judgment of those who assess your peers. We need more young people like yourself who are willing to take time and effort to talk. Clearly, you are not into yourself. You are more giving and that is what we should look to for young folks, for all of them. I do not think we have as many as we should. If we did, it would be a nicer life for all, including young folks who did. In the end it is better to give than receive. Congratulations.

Ms. CORNEY. Thank you.

Mr. BIAGGI. Mr. Cohen, I want you to know that no one is more aware of the importance of counselors and professionals than I. I have a daughter who has been a clinical psychologist working in the educational system in Mount Vernon most of her professional career. We often discuss the different problems, many and varied, in how the counselor continues to lead a normal life after being burdened hour after hour with the problems of others. It is a tribute to their personal resolve and extraordinary inner strength. To persist in the career is a tremendous contribution and it is a peril they undertake. I just have to tell you, in my mind there is no stereotype of a counselor. They are human beings who have chosen a very important profession and who do very, very important work.

Mr. **Cohen**. Thank you. I want you to know one of our rewards is that we get to work with people like Beth and the other students here today.

Mr. **Biaggi**. I am sure it is gratifying.

Mr. Friedman's statements have been extensive and comprehensive. I have two questions. One, would you care to comment on Al DelBello's statement?

Mr. **Cohen**. One of the things I wanted to mention is that the group that has the fastest rising rate of suicide in this country are young black males. Young white males have the highest rate in terms of adolescent group. But the highest rising rate, if you look at a graph, you see a dramatic rise in suicide among young black males. Many of us are very concerned about that.

Mr. **Friedman**. Let me continue on that point. If you look at the increased rates by racial groups, you will find dramatic increases in black suicide rates, particularly in integrated northern counties where what may be certain social taboos or religious taboos that appear to be still preserved in many rural parts of the South seem to disappear in second and third generation living within suburban areas like Westchester. That there are phenomena one can track as to why there are dramatically low suicide rates among young rural blacks and what happens when one moves—is it the pressure of an urban area, the exposure to certain kinds of drug and alcohol behaviors? There are facets strongly needing research at this point because there are different levels of suicide by geography, urban, rural, and by racial groups. As one studies the changes or increases among groups, we may find more of the triggering factors.

Mr. **Biaggi**. Would you like to comment on that, Mr. Owens?

Mr. **Owens**. No.

Mr. **Biaggi**. Mr. Ackerman.

Mr. **Ackerman**. Thank you.

First, Beth, let me tell you how much I appreciated your very, very fine statement, as well as your actions. Let me say that we learn from the Talmud, which is a book of Jewish learning, from the words of Maimonides, who tells us that to save a single life is as if you have saved the entire world. This is what you have done by virtue of the kind of person you are and the training that you have had. You have been the epitomy of success. If we here on this congressional committee, indeed in the entire Congress, with all of the work we do and all the hearings we have and all the millions of dollars that we are talking about spending, can be just as successful as you were with Larry, this whole process will be worth it. So you have our complete admiration for what you have done.

If I can ask something of Mr. Cohen and Mr. Friedman: Mr. Friedman, you threw something into the formula which maybe at first was confusing and, as well, maybe helps us to understand why there is a confusion in the statistics.

You stated that among the things that you look at are some of what I think seem to be provocative actions that some teenagers take—provoking fights that result in homicide, alcoholism, drugs, and driving "accidents." These are things that do not initially appear to be suicides, but are you saying that this is counted in as part of the suicide statistics, or this is a guesstimate?

Mr. FRIEDMAN. No; they are specifically not included in. What I was discussing was that the two highest causes in death rates in these age groups are accidents and homicides. Homicide is a higher rate of death than suicide at this point and dramatically higher among urban groups, dramatically higher among urban black males.

Incredible rates of death by homicide in the 10 to 19 and 15 to 24 age ranges, while the rates of suicide are less than for others.

I speculate that, just as Al DelBello said, to look at single vehicle automobile accidents as to what percent of them might be suicide, I raise the phenomenon of, are not caused homicides becoming a form of suicide among certain groups in this country where the taboo against suicide still prevails.

Mr. ACKERMAN. What you are suggesting then is actually that the number of attempted suicides is probably much greater because actual homicides and accidental deaths, a certain percentage of them, are probably either consciously or subconsciously suicide attempts as well?

Mr. FRIEDMAN. Yes.

Mr. ACKERMAN. Very frightening.

Mr. BIAGGI. In relationship to grants, I like to be practical. You know there is concern for dollars. If we can get $10 million in Mr. Ackerman's bill and $6 million in Mr. Lantos', we will be very grateful. I do not think we should look forward to an enlarging of the program. I think it will be satisfactory to get this underway and establish a national presence and national focus and then have the private sector come in and ultimately do the job and I am sure they will do it well.

One other question, Mr. Friedman, on your hotline. I would like to comment that Westchester County clearly has a very effective structure in place. There is no question about that. In relationship to the hotline, what occurs? Can you briefly describe what occurs when someone calls?

Mr. FRIEDMAN. First, that it is covered round-the-clock by a professional staff. It is our feeling that receiving someone in that state of crisis, the response can be with someone who can triage the seriousness, make the decision as to whether a crisis team might be necessary, or whether it is a largely referral phone call, so that, first, it is professionally staffed by social work or nursing staff by the day by one agency and then switches to psychiatric hospitals. The individual receives either specific direct counseling at that point or referral to an agency. Or if there is an expectation that a suicide may be an immediate act, attempt to get the crisis team, another of the services available in the county, to respond to the individual immediately.

One of the phenomena that needs to be addressed is that largely the callers to hotlines at this point, to things listed as suicide prevention services, tend to be young white women. A major national phenomenon. If you look at who calls and what is the population serviced by this, it is a particular segment of society, a segment that at least at this point has some of the lower rates of suicides.

You have what one of the offered services, yet you have a group that uses it that perhaps should not be your primary targets.

Mr. **BIAGGI**. Who makes the call? Someone calling on behalf of someone or the person themselves?

Mr. **FRIEDMAN**. Usually the person themselves. Many of the calls are not someone immediately going to attempt suicide, but someone who is in the stages of beginning to think of this as an option, beginning to go from the fantasy to the decisionmaking stage. If one can head them off at that point, a highly dramatic result.

Mr. **BIAGGI**. You say the people who are using it have the lowest rate. Isn't it conceivable, logical to believe that because they use it, they have a lower rate?

Mr. **FRIEDMAN**. No; the Miller study, unfortunately, in the Journal of Public Health this summer, which tracked before and after, found very little effects. Whether or not the rates were going down, whether there was such a service introduced. They also found that in the timing that some rates went down for women within this age group, women of this age group are notorious for using ingestion, poison, as a means of committing suicide. Heavy use of pills as opposed to the more direct and lethal, hangings, firearms or other forms. There are major changes in prescribing practices from the mid-1960's to now with different sedatives and the toxicity of individual sedatives being less. I really have a question as to whether you have not had a more dramatic decreasing effect from medication practices, in England, with the type of gas. You can have it if individual physicians would refuse to prescribe to a patient unless that patient came to only them at this point for chemotherapy, for a mental health problem. There is probably nothing worse than an individual client being treated by three separate prescribing physicians at the same time, so that even if each physician is being sure not to give a lethal dose, three nonlethal doses may be lethal.

Also, individual physicians, when prescribing, should prescribe individual amounts that are nonlethal and write for constant referrals not for constant revisits to an office, but to have a relationship to a pharmacy that you give out amounts so that at no point—especially if the client is depressed. These things have had a dramatic effect where ingestion has been the route.

One of the problems has been I think some change in methodology adopted by women, which I suspect, like smoking and lung cancer, you will see a phenomenon increasing. A society becomes more common in its use of smoking or whatever, you will begin to see undesirable increases in certain rates.

Mr. **BIAGGI**. Mr. Cohen.

Mr. **COHEN**. One of the things I like about the bills that are being proposed is that it is not going to focus in on only one particular answer to the problem. Not just hotlines, but that it will include a wide variety of approaches, including the fact that it will include educational programs. I believe suicide is an educational problem.

One of the things we are doing here in Westchester is going into classrooms and helping students redefine friendships, redefine it so that it includes letting adults know when one of your friends is suicidal.

What is happening, of course, is that they are beginning to see that it is the way to go, that it is a good idea to involve an adult. And they are coming forward and letting us know that some of their friends are seriously depressed and possibly suicidal.

We know very often students will talk to other students first before they talk to us as adults. By going in and developing an educational program that helps them see the need to do this, we are able to find kids who really need the help.

Mr. **Biaggi**. Thank you very much for your testimony.

The next panel will be Ann Kliman, Center for Preventive Psychiatry; Ethel Rosally, director of pupil personnel, Yonkers Board of Education; and Louise Latty, chief executive for instruction, New York City Board of Education.

Ms. Kliman.

STATEMENT OF ANN KLIMAN, CENTER FOR PREVENTIVE PSYCHIATRY; ETHEL ROSALLY, DIRECTOR OF PUPIL PERSONNEL, YONKERS BOARD OF EDUCATION; AND LOUISE LATTY, CHIEF EXECUTIVE FOR INSTRUCTION, NEW YORK CITY BOARD OF EDUCATION, A PANEL

Ms. **Kliman**. Thank you. I do thank you for getting the name of the center correctly. Our answering service over the past 20 years insists on saying, "Good morning, the Center to Prevent Psychiatry."

I will not follow the papers I gave you. I would rather respond to what I think are the most crucial aspects of what I heard this morning.

Mr. **Biaggi**. Each of you may follow that procedure if you like, with the assurance that your entire statements will be included in the record. You may proceed as you desire.

Ms. **Kliman**. Thank you.

I am grateful to the speakers this morning, all of whom I do know. There has been precedent for 20 years in Westchester County for school systems to utilize agencies specifically trained in intervention with children and adolescents and youth and, indeed, for 20 years, the Center for Preventive Psychiatry has functioned as a consultant to schools in Westchester, Fairfield, and New York Counties.

We have worked with them to design workshops and consultations on a purely preventive basis, as well as a preventive or interventive basis. They were designed to help resensitize and reeducate school personnel, and that means all school personnel; to recognize students who are at high risk and to facilitate referral effectively and efficiently. In the material an outline of the workshop is covered.

One aspect, however, has been neglected by the majority of schools by even bill H.R. 1894, and that is the statistics available on preadolescent suicide. All of the panel members this morning made some referral—and at the end more referral—to death by accident. Very often, with both children and adults, a suicide is an accident which we all allow to happen. I recommend that we not only look at one-car crashes or boat accidents or bike accidents, but that we also look at all childhood, starting at about age 3.

Mr. Chairman, the only denial left among all of us who have the courage to look at the depression and the terror and the helplessness and hopelessness that adolescents feel at the time that they suicide, we now must also look at children, because in the past 27 years I have worked with children at the age of 3, 4, 5, 6, 9 and 12 who actively and determinantly have attempted and/or achieved 62 suicides. So, we must look at all of the accidents that occur.

I also think we must take a look at the mythology that surrounds suicide. One of the most common, of course, those who talk about it, don't do it. Statistically, that is untrue.

Also, very important and I think George Cohen and the group of high school students that he has trained have brought this out very clearly, one of the worst myths is, if you talk to a child or adolescent about suicide, you will put thoughts in their head. That is not true. There certainly is a contagion for suicide, but ideas are not put in the head. It is essential that school personnel learn the signs and signals of depression. To know the difference between a reactive depression, which is certainly not psychotic and rarely, if ever, leads to suicide, and to know the difference between that and a psychotic depression in which helplessness and hopelessness characterize the feeling and in which there are no other options which are available.

I think terribly important, we must all learn that the usual rules of confidentiality, trust, which apply when we are an adult dealing with a child or an adolescent, when we are a friend dealing with another friend, the laws, the rules, the ethics, the morality of confidentiality must not be adhered to when a life is at stake, because most often the penultimate act of a suicider's life has been to confide that, indeed, the idea is in the head, that there are thoughts about it, that there is a plan and indeed that there is access to carrying out the plan.

It is essential that school communities form an alliance with their psychotherapeutic, their medical and their pastoral communities. The reason I say that is, Westchester is a unique county in terms of richness of services that are available. That does not change the essential fact that there is no parent in the world who is comfortable and very few who are even willing to hear about their own child's suicidal ideas. So the denial of parents, not just the community in general, the denial of parents often makes it impossible to effect referral to an agency.

I would like to add to Al DelBello's concept of a Federal hotline, which he described as for someone who is thinking about suicide. I would like to see a Federal hotline for people who know that someone else is suicidal and, if it is a child under 18, that the parents are unwilling or unable to seek help for that child. And in this county and in other counties, I spend more than half of my professional life trying to pick up the pieces of a family after a child or an adolescent has suicided.

I often recommend that when necessary a principal refuse to allow a suicidal child into school because the school cannot be a safe environment for a suicidal child. I have often recommended, and my husband, who is a lawyer, tells me I could get into a lot of trouble for this, that, if necessary, a school counselor or principal or social worker or a teacher, when confronted with an acutely suicidal child, and that means a child who either has made an attempt or gesture before, who has a plan and who has the ability to carry it out, that is an acute psychiatric emergency.

I would beg that somehow written into this, when this is true, a school guidance counselor, a clinical psychologist, a psychiatric social worker, is not allowed by law to effect hospitalization or to give psychotropic medication. Therefore, I would wish that there were an 800 number, whether you are calling from Butte, MT, or Sioux Falls, S.D., or Peekskill, N.Y., or Dayton, OH, no matter who is available in your State, that someone, be it a student or teacher or social worker or a neighbor, could call a hotline where there would be a registry and they could get the name of the nearest mental health facility to treat an acutely suicidal child, adolescent or young adult, say college student, and would have the backup of a police escort, whether county or city or village or State, police escort to get that person there because there is no way in the world that the biggest, strongest man can restrain an acutely suicidal person and drive a car at the same time.

I really applaud these bills. I hope that somehow it could be possible to add to both that this deal not only with adolescents but with adults and that we look very carefully at the kind of accidents which do occur.

I also applaud George Cohen and his group. My only concern is that most self-help groups made up of students do not have a George Cohen. They do not have a built-in supervision and support system. I have been doing this work for 27 years. I cannot do it in isolation. I need to be able to talk to my peers about it. If we design peer support groups, if we train young children to do this intervention, which this morning we saw clearly they can do brilliantly. We must also give them support and supervision to help them do it.

I thank you very much for allowing me to testify. I congratulate you on your courage in breaking through the denial which has plagued this country for more than 27 years, and I hope the bills go through.

[Prepared statement of Ann S. Kliman follows:]

PREPARED STATEMENT OF ANN KLIMAN, M.A., DIRECTOR, SITUATIONAL CRISIS SERVICE, THE CENTER FOR PREVENTIVE PSYCHIATRY

Childhood and adolescent suicide can only begin to be prevented when we, the responsible adults, stop denying that our children can and do kill themselves. This denial prevents us from hearing and responding appropriately to the many cries for help the vast majority of potential suiciders make. The natural environment of children is school, and schools are designed to be educative institutions. Schools also have the advantage of access to parents and community agencies.

There is precedent for school systems to utilize the services of therapists trained in prevention, intervention and postvention of suicide, For many years The Center for Preventive Psychiatry has functioned as a consultant to schools in Westchester, Fairfield, and the New York Counties. Originally, schools requested consultation only after a suicide had already occurred. Increasingly, requests for workshops and consultations are being made purely preventively. They are designed to sensitize and reeducate school personnel to pupils at-risk to help establish "crisis teams" in each school, and to facilitate referral of a high-risk suicidal student efficiently and effectively. An outline covering the material presented at these "continuing education" workshops is attached.

The Judge Baker Child Guidance Clinic in Boston has replicated The Center of Preventive Psychiatry's school consultation work with their "Good Grief" program, also with considerable success.

In 1984 Four Winds, an inpatient psychiatric hospital, established the Committee on Sudden Adolescent Death—an interdisciplinary group of therapists and schools.

One aspect of suicide, however, usually has been overlooked. Even Bill H.R. 1894 neglects to include statistics on pre-adolescent suicides, and does not include "disguised" suicides—accidents which the suicider allows to happen in cars, on bikes, in boats, with poisons, by drowning, by falling, by smothering, and by hanging. If we include deliberate accidents in the student population, I believe the statistics on suicide would increase even more alarming than they already have risen.

I would like to stress that I believe it is not only appropriate but essential that school personnel (and the public in general) be dissuaded of certain myths concerning suicide which include:

1. Children do not suicide.
2. Those who talk about it don't kill themselves.
3. They'll outgrow it.
4. It's just a stage.
5. If you talk to students about suicide you'll put thoughts in their heads.

It is essential that school personnel learn the signs and signals of severe depression since depression usually precedes and coincides with suicide. We must find effective ways to combat the wide-spread idea that suicide is romantic (Romeo and Juliette) or heroic. Suicide is neither—it is the ultimate act of desperation when helplessness and hopelessness can no longer be tolerated. No other options appear to be available.

It is essential that school personnel learn to combat the contagion of suicide. For students who are already at-high-risk the successful suicider is often seen as encouragement for the student to suicide.

It is essential that school personnel learn and teach their students that the usual respect for confidentiality must not apply when a life is at stake. When potential suiciders tell someone of their plan to kill themselves it often the penultimate act of their lives. While most of us can bear the anger of a suicidal student for sharing their suicidal intent with appropriate others, few of us would wish to bear the guilt that we did not intervene in a preventable suicide.

However, we must also bear in mind that the best education and the best psychiatric treatment will not prevent all suicides. Some suicidal students cannot be stopped, but they are, hopefully, a tiny minority compared to those who can be helped to find life liveable again.

It is essential that school personnel establish an alliance with their local psychotherapeutic, medical, and pastoral communities. Often when a parent is confronted by school personnel with a student's potential for suicide, the parent denies the reality and becomes furious at the school. A pediatrician, family doctor, or clergyperson might be able to help the parent get psychiatric help for the vulnerable student. If not, it is in the power of the principal not to allow the student in school until a psychiatrist can assure the principal that the child well be safe in school. If the pupil is acutely suicidal (talks about committing suicide, had made suicidal gestures, has a plan and the ability to carry out that plan) and the parents refuse medical help, I would urge school personnel to immediately escort that pupil to the nearest hospital with a child or adolescent psychiatric unit. I recognize that this appears intrusive. However, I would rather see them furious in my office than tearful at the funeral. I would add that when parents continue to deny the suicidal plans and behavior of their children so obvious to others, the parents are in need of psychotherapeutic help. It is not rare for children to make a suicidal attempt as a reflection of the family's internal anger and helplessness.

It is essential and appropriate that schools respond immediately and effectively after a student suicides. It is crucial that a telephone call be made to every member of the school staff to notify them of the suicide. The following morning there should be a pre-class meeting of all personnel to: share information, dispell rumors, to prevent distortions, to provide a support system for personnel, to prepare them to meet the needs of the students, to help them understand that staff and students each will react to the suicide in his or her own way—and to expect a variety of responses. At this meeting plans should be implemented to organize and activate special events at school (attending the funeral, holding a memorial assembly in which the suicider is mourned but not glorified). Guidelines should be reviewed to: help students express anger, guilt, resentment or fear; talk to skilled professionals when necessary or desirable; and communicate with each other and their parents. After the first day of school there should again be an all-staff meeting to discuss the day's events and to assess the urgency of those pupils at risk, as well as to support the staff. Follow up meetings should be held, as necessary, over the next few weeks. Equally important, the school staff should be alerted to the possibility of anniversary reactions, and on the first anniversary of the suicide some acknowledgment should be made.

I applaud Bills HR 1099 and 1894 although, as stated earlier, I would include children as well as adolescents in HR 1894, and urgently plead that they be passed and become our national policy.

Childhood and Adolescent Suicide, Prevention, Intervention and Postvention Workshops for Schools

I. A LOOK AT SUICIDE TODAY

A. Myths.
B. Variables at different age levels.
C. Depression and its signs: (1) Reactive; (2) Neurotic; (3) Psychotic.
D. The Romanticization and Libidinazation of Death.
E. Responsibility: (1) The Schools; (2) The Parents; (3) The Peers; (4) The Societies.
F. Epidemiology and Contagion.
G. Opportunities for Prevention.

II. INTERVENTION

A. Early recognition: (1) Evaluating the risk; (2) Establishment of systems of referral and support; (3) The trap of confidentiality—it does not apply when a life is at stake; (4) The traps of avoidance and denial; (5) Establishing an alliance with parents; (6) Establishing an alliance with the therapeutic, medical, and pastoral community; (7) Educating students, parents, and school personnel; (8) The importance of follow up.

III. POSTVENTION: THE RESPONSE OF THE SCHOOL

A. Immediate meeting of *all* school personnel with a trained therapist.
1. To share information and prevent distortions.
2. To provide a support system for personnel.
3. To prepare them to meet the needs of the students: (a) Out-of-phaseness of school personnel; (b) Out-of-phaseness of students; (c) Out-of-phaseness of parents; (d) To assess the urgency of those at risk; (1) All members of the immediate family.
4. To organize and activate: (a) Special events at school; (b) To establish guidelines for helping students: (1) To express grief, anger, resentment; (2) Talk to skilled professionals when necessary or desirable; (3) To deglorify the suicide (It is not heroic); (4) To communicate with each other and their parents.
B. After school meeting of all Personnel.
C. Follow up.
D. Follow up 1 year later to prevent the destructive aspects of anniversary reactions.

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Mr. OWENS. Thank you. Ms. Louise Latty.

Ms. LATTY. Good morning and thank you very much. I am sorry the chairman had to leave, but I did want to thank you at the very beginning and applaud both Congressmen Owens and Ackerman for this bill. It is certainly a beginning. We in New York City had felt, over 1 year ago, it was important to begin this effort despite what people were saying, that suicides were not really occurring in New York City in our public schools. I would just like to review with you some of the things that we have done.

My name is Louise Latty and I am chief executive for instruction for the New York City Public School System. The board of education is responsible for nearly 1 million students attending approximately 1,000 schools throughout the five boroughs. Congressman Ackerman has said over and over again that 6,000 American young people between the ages of 15 and 24 will take their own lives this year and many more will attempt suicide. Of the 100 deaths that will occur in New York State, half may be expected to occur in New York City.

It has been estimated that as many as 24,000 additional teenage suicides will occur this year. These include deaths resulting from drug abuses, alcohol abuse, and motor vehicle accidents. These statistics represent a national disaster that cuts across geography, race, and economic status.

The real tragedy is that these deaths are preventable. We know that suicide is a youngster's response to stressful situations which are seen as being beyond the capabilities of the individual to manage.

We know that 80 percent of all teenagers who commit suicide cry out for help, giving one or more signs of their intention beforehand.

We have demonstrated that awareness of these signs and appropriate responses for prevention can be taught to teens and those who work with them through pilot programs in the schools.

In the early fall of 1984, the New York City Board of Education established a suicide prevention task force composed of key administrators throughout our school system. After careful scrutiny of the issue and its alarming dimensions, we realized that suicide awareness and prevention education had to begin at once, and that it had to involve both pedagogical and nonpedagogical personnel, parents and students.

Since that time we have introduced personnel in the 32 community school districts, high schools and central administration to the issues of teenage suicide. Through a pilot program, individuals in the intermediate, junior high school, and high schools within 2 of our 32 community districts have received more intensive training in recognizing the warning signs of suicide and implementing strategies for prevention. Each of these schools has developed a school-based suicide prevention action plan designed to disseminate effective prevention techniques throughout the school community.

I would like to tell you about a boy I will call Jose, who showed us how our efforts are paying off.

Jose's family came to New York from Puerto Rico when he was just a baby. His parents worked hard to succeed in their new home. An only child, Jose was expected to do well in school and make his family proud of him. He did do well; by his junior year in high school, he served in the student government, played on the baseball team and was selected to represent New York City as an exchange student.

Something happened to Jose in the spring of his senior year. His friends noticed it after Jose and his girlfriend broke up. He began to withdraw from the activities and people he once enjoyed. Telling the baseball coach, "There is no point in trying any more," he quit the team and gave his prize catcher's mitt to his best friend. Formerly above average, Jose's grades took a nosedive. His mother was alarmed at Jose's rapid loss of weight and disinterest in family and church activites.

Jose's school is one of those participating in our pilot suicide prevention project. His coach and members of his class recognized the signs that Jose was depressed and might be considering suicide. They knew and used the appropriate responses, confronting him and discussing their suspicions. They knew who to turn to for help in connecting Jose with professional counseling.

It was discovered that a number of stressful situations had brought Jose to thoughts of suicide; the loss of his girlfriend, the loss of parental attention to a newly born brother, and the impending loss of familiar surroundings and friends through graduation and plans to attend college in another State.

Jose received the help he needed because his friends and coach knew what to look for and how to respond. He was lucky. In 1983, there were 84 New York City youths in the 15- to 24-year-old age group that were not so lucky.

Our long range goal is to expand and intensify suicide prevention activities to include every public school student, grades 8 through 12, in New York City. We need additional resources to reach this goal. H.R. 1099, introduced by Mr. Ackerman, Mr. Biaggi, and others, is responsive to our needs and we support it. With sufficient increased funding, the New York City Board of Education would implement prevention programs citywide. Training and intervention specialists would be available to provide services to staff, students and their families.

It is now time for the Federal Government to provide the assistance necessary to put our knowledge into broader practice. Education and intervention can reverse the rising rate of teenage death by suicide.

We are grateful for you, your concern and interest in addressing this problem. We look forward to working with you on this issue and will be glad to provide any assistance or further information that would be useful to the group.

I just want to, personally, thank both of you for your interest and efforts in helping us with this major, major effort. Thank you again.

Mr. **Owens**. Thank you.

Ms. Ethel Rosally.

Ms. **Rosally**. I also thank you for inviting me this morning to testify and congratulate you. My name is Ethel Rosally. I am the director of Pupil Personnel Services and my department is responsible for the delivery of counseling medical, psychological, and social services to students in the Yonkers school district.

We have counselors in all our middle, high school, and a few in the elementary schools. Psychologists and social workers are assigned from 1 to 2 days per school, depending on the enrollment in the building. We have a part-time psychiatrist and a physician who serves as a chief medical officer.

The staff is locally funded with the exception of a few that are federally funded.

All Pupil Personnel Services members have been inserviced and all faculty members throughout the district have been informed of our suicide prevention procedures. They have been taught observation techniques and provided with counseling guidelines. Additionally, a list of emergency psychiatric services available within the community have been distributed to our administrators and Pupil Personnel Services staff.

Our suicide prevention program deals with at-risk youngsters on a one-to-one basis. Students appearing to be depressed, have expressed some desire to kill themselves or attempting to physically harm themselves are referred to a team member. The member interviews the youngsters and ascertains the nature of the problem. The information gathered is shared with the building principal. A decision is made as to whether a needed hospitalization or referral to a community organization is necessary.

Regardless of the decision reached, the information is shared with the child's parents. A number of cases have already been handled successfully and confidentially.

I am in support of H.R. 1894 compared to H.R. 1099 to maintain grants available for teenage suicide prevention programs. H.R. 1894 appears to be a more comprehensive approach to the problem and provides for the establishment of in and out of school programs. However, the amount of funding allocated seems to be inadequate. Six million will not serve a significant number of school districts. The initial allocation of 6 million should be increased to 10 million and by 20 percent each year.

As youth suicide prevention programs are implemented, more and more youngsters might surface in need of counseling and intervention services.

Again, thank you for inviting me.

[Prepared statement of Ethel Rosally follows:]

PREPARED STATEMENT OF ETHEL ROSALLY, DIRECTOR OF PUPIL PERSONNEL SERVICES, YONKERS SCHOOL DISTRICT

My name is Ethel Rosally. I am the Director of Pupil Personnel Services. My department is responsible for the delivery of counseling, medical, psychological and social services to students in the Yonkers school district.

Presently we have counselors in all our middle and high schools and a few in the elementary schools. Psychologists and social workers are assigned from one to two days per school, depending upon the enrollment in the building. We have a part-time psychiatrist and a physician, who serves as chief medical officer. The staff is locally funded with the exception of a few that are federally funded.

All Pupil Personnel Services members have been inserviced and all faculty members throughout the district have been informed of our Suicide Prevention Procedures. They have been taught observation techniques and provided with counseling guidelines. Additionally, a list of emergency psychiatric services available within the community have been distributed to our administrators and Pupil Personnel Services staff.

Our Suicide Prevention Program deals with at risk youngsters on a one-to-one basis. Students appearing to be depressed, have expressed some desire to kill themselves or have attempted to physically harm themselves are referred to a Pupil Personnel Services team member. The staff member interviews the youngster and ascertains the nature of the problem. The information gathered is immediately shared with the building principal. A decision is made as to whether immediate hospitalization or referral to a community agency is necessary. Regardless of the decision reached the information is shared with the child's parents.

A number of cases have already been handled successfully and confidentially.

I am in support of HR 1894:

To establish a commission to conduct a study of the problems of youth suicide in the United States for the purpose of providing guidance in developing national policy, and to establish a grant program for states, political subdivision of states, and private non-profit agencies for programs to prevent suicide among children and youth.

Compared to HR 1099—to make grants available for teenage suicide prevention programs; HR 1894 appears to be a more comprehensive approach to the problem, and provides for the establishment of in and out of school programs.

However, the amount of funds allocated is adequate. Six (6) million will not serve a significant number of school districts. The initial allocation of six (6) million should be increased to ten (10) million and by 20% each year. As youth suicide prevention programs are implemented more and more youngsters might surface in need of counseling and intervention services.

Mr. OWENS. Thank you.

Ms. KLIMAN. Mr. Chairman, may I add one point? I believe in the obligation and opportunity for a school system to intervene with other students within the school following a successful suicide or a known suicide attempt. There may at that point be nothing that can be done for the child who is dead, but for all of the children in the school who knew him, both those who liked and disliked him, it is a crucial opportunity to help them understand that suicide is not romantic, that suicide is not heroic, that suicide is not sexy and it is not an option for any young person, at least unless he is a double-agent for the CIA and has just been caught by the enemy and about to be tortured. Then maybe the cyanide pill is an option.

Short of that, it should not be an option for young people and I believe it is the obligation of the schools to educate them to that.

Mr. **Owens**. Ms. Kliman, as a result of your 27 years' experience, what would you recommend as the optimum staffing pattern needed in high schools? There will never be enough money to go around, but if you had it, what would be the optimum staff?

Ms. **Kliman**. I come from a prejudice, Mr. Owens. It makes me very worried when this starts in eighth grade or in a high school. I believe that this education must start in preschool and work all the way through. I believe that the vast majority of severely depressed adolescents can be picked up in childhood as depressed, either the defense against depression, hyperactive kids, over-excited kids, inattentive kids—but that it can be picked up in childhood, and I believe, in early prevention, as early as possible.

In terms of a high school, I would say the people here probably could tell you better than I could what the optimal staff is. I think what is necessary is, besides the staff of the high school, that is being used, that there also be outside consultants who can be called in literally on 5 minutes notice to come in and consult on a particularly difficult case, who are able to do ongoing supervision, not because these people are not competent but because new issues come up constantly.

I think you have to build in, and I would defer to both of you in terms of who the people should be—I know I am currently working in Westchester with what they call crisis units in each school—not each school system—where people come not only psychologists and social workers and counselors, but also from the other faculty and from the students. And they work together.

But I am not the one to decide who should be on staff.

Mr. **Owens**. I have another question for Ms. Latty before I turn it over to Mr. Ackerman for final questions.

In 1983, I think you said you had more than 80 suicides in New York City schools?

Ms. **Latty**. That is what the research shows.

Mr. **Owens**. Isn't that an epidemic? I do not remember reading anything unusual about it.

Ms. **Latty**. As I mentioned, when we first decided we needed a task force just to study the problem, we were told that there weren't any statistics that indicated that New York City youngsters had committed suicide. But as we began to uncover things, we did find clear evidence to indicate that there had been suicides that were not listed as suicides per se.

Mr. **Owens**. So there is a major reportinq problem in New York City and probably other urban areas?

Ms. **Latty**. Absolutely. In one of the districts where this youngster came from, a true story we are talking about, as we began to meet and uncover and had crisis intervention teams within schools within these districts, we began to see that there were specific problems and people had identified, through just talking, that there were some suicides in the schools.

Mr. **Owens**. Before we are evicted, Congressman Ackerman, would you like the last comment?

Mr. **Ackerman**. Thank you very much, Congressman Owens.

Let me very briefly congratulate this panel on a very professional and expert testimony, and to say that those of us who are trying to do a job for our neighbors who we represent are greatly appreciative. I don't know if you realize it, but you have been testifying before a librarian, a cop and a teacher. As your fellow citizens, we greatly appreciate your professional expertise in this area.

Let me just not be negligent in singling out Louise Latty from my city in saying it was through initial discussions and suggestions with your offices back at the Board of Education that the genesis for this particular bill germinated. So we do thank you.

I think we are just about on time, a minute and a half late, which for a congressional hearing I think is fantastic.

I thank the people who have provided us with the setting. Thank you very much.

Mr. OWENS. Thank all the witness. This hearing of the Subcommittee on Elementary, Secondary and Vocational Education is hereby adjourned.

[Additional information submitted for the record follows:]

[Whereupon, the hearing was adjourned.]

PREPARED STATEMENT OF PATRICIA ZALAZNIK, M.A., MINNEAPOLIS, MN

Mr. Chairman and distinguished members of this subcommittee.

My name is Patricia Zalaznik and I am a member of the American Home Economics Association, which has 30,000 members nationwide. I teach Home Economics at a high school in suburban Minneapolis, Minnesota. For the past several years, I have taught a course on the subject of death and dying, with units in living preventively and, when necessary, prevention of suicide for teens. I support the concern for suicide among adolescents that is reflected in HR-1894 and HR-1009, and I appreciate this opportunity to comment on the subject of school-based programs for preventing teen suicide, from the perspective of a home economics teacher.

Background

The subject of death and dying was the thesis for my Master's Degree in Home Economics at the University of Minnesota in 1976. In the course of preparing my thesis, I developed a secondary school curriculum for coping with death and dying, including materials on prevention of adolescent suicide. The curriculum is entitled Dimensions of Loss and Death Education, and it is published by Edu-Pac Publishing Company in Minneapolis. It has been well received; to date 1,500 copies have been sold. Hannelore Wass, editor of Death Education, a journal, reviewed this curriculum in the fall of 1982 and wrote:

> "In my opinion, the author has applied valid criteria, identified significant topics, and listed appropriate objectives. What comes after that, however, is not found in any one place in the death education literature. Here is the author's unique contribution. She presents a wealth of learning activities for various subject items she believes are suitable for achieving the stated objectives. Most of these are excellent."

The development of my curriculum came as a result of questions and observations raised by the death of my own teenage son (though not from suicide), as well as from issues relating to death raised by many students in my Consumer and Homemaker (home economics) classes in family life, child development, and human relationships. From these experiences, I discovered a need in teenage students for skills to aid in dealing with loss and death within the family, at school, and in the community. Coping with the suicide of a classmate or with one's own suicidal thoughts clearly falls within that need.

Statement of the Problem

Self-destructive behavior in adolescents is not a problem unique to the 1980's, but it has become of particular concern in this decade. Current statistics demonstrate a sharp increase not only in adolescent suicide but in risk-taking activities and self-destructive behavior generally. By no means is this limited to the taking of one's own life. Experimentation with drugs and alcohol remains a present danger, as do more subtle forms of self-destructive behavior such as anorexia and bulimia. But it is the ultimate act of adolescent suicide which receives the most press; it is the act which can affect an entire school and community.

Authorities in adolescent behavior do not have a simple answer for the increase in self-destructive behavior in today's teens. Many believe that it is related to the adolescent's inability to cope successfully with the pressures of the complex world of the contemporary adult. These experts recognize that the family less often is a source for learning successful coping behavior in times of adolescent stress. Divorce or separation of the parents frequently leaves an adolescent without an adult role model at home. Statistics and projections indicate that 40% of all children will live in a single-parent household at some time before they are 18 years old. It also is predicted that by 1990 from 70% to 80% of women ages 20 to 40 will be in the labor force. In fact, many believe that school is the only consistent, dependable aspect in the lives of large numbers of young people and that educators "are in a unique position to identify students who need help and then refer them to appropriate personnel" (Swanson, 1984).

The Role of Consumer and Homemaker Education (Home Economics)

Many schools, including my own, provide courses in skills for individual and family living through the home economics department. These courses, funded in part by federal dollars for

Consumer and Homemaking Education available under the Carl D. Perkins Vocational Education Act of 1984, address students' needs for information in all facets of family life. It follows that if school based programs for providing skills in coping with today's pressures (relating specifically to suicide prevention when necessary) are introduced into a curriculum, those programs would be a logical extension of the existing home economics courses in family living. To place them there permits simple and cost-effective introduction of prevention programs to the curriculum, adding no more to the students' workload and expending little, if any, additional teacher and classroom resources.

Home Economics teachers typically have valuable background courses in family life, child development, psychology, sociology, health, and other areas which give the broad base from which to begin exploration and teaching in coping and in suicide prevention. My own experience suggests that instruction in coping with loss and death is a vital part of that instruction. Students often seek out home economics teachers for answers to questions in their personal lives. To use suicide as an example, a student once stopped me in the hall to ask, "When someone talks of suicide, he won't really do it, will he?" In dispelling this myth, I used both a cognitive (intellectual) and an affective (emotional) response. Home economists are trained to provide both.

A further strength of the home economics courses in family living is that they are an "applied field of study." The instruction benefits the student as well as those outside the classroom with whom the student comes in contact. A student who is not himself "distressed" may, by virtue of the training in a family skills course, become more aware of warning signs in fellow students and thus may become critical in interceding in potentially self-destructive behavior. In all but immediate crises, this can amount merely to recognizing the harmful behavior and reporting it to adults with appropriate training. But, most young people are hesitant to ask a fellow student if he or she is thinking of ending his or her life, yet the research indicates that direct questioning is an extremely effective strategy if it is followed by seeking appropriate adult guidance. Education in coping with, for example, death and loss prior to confronting a crisis helps teens cope with those situations in a healthier manner; an uninformed teen may actually facilitate self-destructive behavior without realizing it.

My own home economics classes originally included a course called family living which started with personal relationships, moved to preparation for marriage, then continued through the family life cycle ending with a brief unit on death. Gradually, the course was modified, trimesters were instituted, and now there is a separate course entitled "Dimensions of Loss and Death." It has become an extension of the family life courses taught within the home economics department of my school.

A Sample Curriculum

A unit on suicide and self-destructive behavior is Unit XIII of my curriculum. Given the interest in that area by this Subcommittee, I have attached as Appendix I, a model of what I currently teach. The format includes objectives in cognitive (intellectual) and affective (emotional) learning experiences. In actuality, these are not separate and the intent is to emphasize both types of experiences, not simply to provide logical information, a format derived from Bloom and Krathwol (Bloom and Krathwol, 66, 67).

I also have attached, as Appendix II, a copy of Unit XVII of my curriculum, which relates to "living preventively." Current thinking among professionals studying adolescent suicide focuses on education in stress management and coping skills rather than on suicide prevention per se. For example, on October 5, 1985, I attended a course taught by Barry D. Garfinkle, M.D., a psychiatrist with 11 years experience in the study of suicide, and Harry M. Hoberman, Ph.D., Division of Child and Adolescent Psychiatry at the University of Minnesota Medical School. Special emphasis was placed on teen suicide. Garfinkle and Hoberman suggested that an increase in education in suicide prevention may be counter-productive, and that stress and crisis education should be the preferred approach. The occurrence of "clusters" of teen suicide was said to indicate dangers in giving too much information on suicide itself. Unit XVII (of my curriculum) includes risk-taking behaviors, stress, crisis, and intervention materials. Both parts of the curriculum are appended to this testimony.

Other Components of a School-Based Program

An effective school-based program for suicide prevention should include not only the teaching of acceptable skills, methods, and techniques for dealing with feelings (the curriculum), but also a program for early identification by all school personnel of students who are troubled, which is itself accompanied by a system for subsequent referral to appropriate professionals for help. In order to implement an effective program, all teachers need training about teen suicide. Therefore, in addition to a curriculum, I recommend the following as essential elements of a comprehensive school-based program.

1. Commitment of the entire school administration to a comprehensive teen-suicide education program.
2. Community (e.g. PER committees, advisory committees, etc.) involvement and commitment.

3. Comprehensive curriculum development including:
   - Curriculum for in-service teacher education.
   - Curriculum for high school level.
   - Curriculum for junior high level.
   - Work groups for school personnel working with at-risk teens.
   - Component for all teachers in the system. A unit and/or complete curriculum for a class or unit to be taught. It could be elective or as a requirement. (My high school has a Cardio Pulmonary Resuscitation (CPR) requirement for graduation, for example.)
4. Formation of support groups for:
   - students at-risk groups (potential suicides).
     - bereaved students
     - concerned persons
     - new students in school, particularly distressed students
5. School counselors who are available for immediate referral.
6. Programs with mental health and medical personnel in the community to identify teens "at risk" (suicide victims often contact a physician before attempting suicide with presenting symptoms such as depression as a cry for help.)

7. Programs with law enforcement people to identify teens "at risk".
8. Evaluation specialists to continue an on-going evaluation process. In terms of time, there are needs to be met in prevention, intervention, and postvention.

Conclusion

In conclusion, Mr. Chairman and Members of the Subcommittee, my purpose in presenting this testimony is to introduce the viewpoint of a home economics teacher regarding school-based programs for prevention of teen suicide. I have done so on the basis of my own experience, research, study and curriculum for teaching in the field. If I were to emphasize one point over any other, it would be that CONSUMER AND HOMEMAKER EDUCATION (home economics) classes are already in place in many secondary schools throughout the country, and that these courses, with their emphasis on family and individual skills for living, provide an existing forum for rapid introduction of programs to prevent teen suicide in the school system.

Thank you for the opportunity to submit this testimony. Should you need additional information on my consumer and homemaker education program in death and dying, I will be pleased to supply it.

* * *

This testimony is provided courtesy of the American Home Economics Association, 2010 Massachusetts Avenue, NW, Washington, D.C. It represents the views of the author, which although consistent with Association philosophy generally, have not been formally reviewed for the purposes of establishing an official Association position.

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APPENDIX I

Sample curriculum for unit on Suicide and Self Destructive Behavior, Unit XIII of Dimensions of Loss and Death Education: A Resource and curriculum Guide, by Patricia Weller Zalaznik, published by Edu-Pac Publishing Co., Minneapolis, Minnesota (1979); All Rights Reserved.*

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XIII. SUICIDE AND SELF-DESTRUCTIVE BEHAVIOR

A. **Objective:** Recognize the complex nature of suicide.

B. **Objective:** Awareness of the incidence of suicide in the U. S. and the populations affected.

C. **Objective:** Become familiar with ways of recognizing a potential suicide.

D. **Objective:** Awareness of ways of preventing suicide.

E. **Objective:** Become familiar with the idea and value of postvention following suicide.

Content	Cognitive Learning Experiences	Affective Learning Experiences
1. Terms specific to this area of death or near-death such as crisis, lethality.	1. Look up meanings of list of terms relevant for this section. (Terms from Grollman, Kastenbaum, Schneidman.) (WB-42)	1. Pre-test—on feelings about suicide: questions such as "Do you believe that people who talk about suicide won't attempt it?" (WB-43)
2. Suicide data reported and underreported.	2. Suggested required reading: Grollman. Remaining readings can be divided according to student interest and ability. Give oral report on major points to entire class.	
3. General background information on suicide.	3. Required reading: A. Public Affairs pamphlet. B. Grollman's "What You Should Know About Suicide."	3. Look an pre-test to see if items originally selected might warrant a different answer. Why not change answers?
	Listen to teacher-prepared lecture with visual aids on Schneidman's information on suicide. View film to become familiar with suicidal clues, behavior and so forth.	Discussion of feelings aroused by topic: open-end questionnaire such as "The topic of suicide makes me feel . . . ."
	Write a brief summary of lecture information.	

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4. Suicide and the teenager: Suicide is second or third leading cause of death ages 13-19, and this is under-reported. [Depends on whose data used.]	4. Listen to cassette. View films in order to become familiar with phenomenon of adolescent suicide. Search for additional materials specific to adolescent suicide. Read and report.	4. Write one or more page essay on "Sorting It Out." State your current feelings and beliefs about teenage suicide.
	Buzz groups: answer two questions by brainstorming: a. What are causes for adolescent suicide being high? b. What are ways students identify that could be alternatives to suicide? Share answers with class; follow-up by obtaining additional research.	
	If a significant other in student's life said, "You would be better off without me," or gave other clues, how could one respond? Why? Support reasons from cassette, films, readings and so forth.	Respond in writing to this case study.
5. Theories concerning suicide.	5. Read Grollman. Other selected readings.	
6. There are differences between attemptors, people who commit suicide and future suicides.		
7. There are clues to suicidal behavior.	7. Read Grollman. Search for information on clues. Share with class.	7. In student-chosen pairs or threes using third-party technique, discuss possible times when people have given clues. Recall your responses. "Third party" means referring to another person like "I have a friend who–" instead of revealing identity of self or others.

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8. Some of the major variables in a suicidal population are age, sex, race, marital status, socio-economical status, mental health.	8. Make collage illustrating Grollman's identification of "those most susceptible to self destruction."	8. Small groups share collages. Explain feelings regarding the susceptible population. Does it differ from what students imagined it might be? Can students identify anyone in acquaintanceship who might fit this category? Are there responses students could or would make toward such persons?
9. Attitudes of various age groups toward suicide.	9. Suggested reading of Grollman. Identify other resources.	9. Discuss differences.
10. Attitudes of various people on suicide (personal, religious, philosophical).	10. After reading, prepare a panel to further explore various attitudes and present to entire group.	
11. There are agencies or person able to respond in a suicidal crisis.	11. Listen to resource person on services available. Compile personal list as though for friend encountering a crisis.	11. Role-play—person comes to another saying, "I don't know where to turn or what to do." What are responses that could be made?
12. Social changes in attitudes on suicide. (Will it be favored more in future?)	12. Divide students so each group does one suggested reading. Present summary class. Read Grollman; view film, "A Case of Suicide."	
13. Consequences of suicide to survivors.	13. Make a poster or set of flip charts expressing consequences outlined in reading and film.	13. Answer in small groups: "What are ways in which a person could best help survivors of a suicide?" How do I relate to these ways?

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PRE-TEST FOR UNIT XIII
SUICIDE AND SELF-DESTRUCTIVE
BEHAVIOR (WB-43)

Name ______________________________

Period _____ Date ____________________

1. Do you believe the common saying that people who talk about suicide will NOT try it? Why or why not?

2. Do you know approximately how common suicide is for teenagers, young adults or adult people?

3. Have you ever known anyone who talked about or tried suicide? Can you briefly describe? (You may pass on this question or disguise the identity of the person. You may be concerned about loyalty or confidentiality.)

OPEN ENDED QUESTIONS:

4. The topic of suicide makes me feel . . .

5. The part I don't understand about suicide is . . .

6. If my best friend said he/she was considering suicide or gave clues, I would . . .

7. Some reason(s) for adolescent suicide could be . . .

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VOCABULARY SHEET FOR UNIT XIII
SUICIDE AND SELF-DESTRUCTIVE
BEHAVIOR (WB-42)

Name ____________________

Period ____ Date ____________________

alternatives

attemptors

consequences

crisis

depression

incidence

intention

intervention

lethal

postvention

potential

prevention

suicide

subintention

variables

Other terms which need to be added and explained are:

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XIII. SUICIDE AND SELF-DESTRUCTIVE BEHAVIOR
(WB-44)

Read the article below and react to it on the next page. It is the true story of a young man who took his own life. Mike was a hockey co-captain, had been elected "Snow King" in his high school, and in no sense of the word was he a loser. But on February 10, 1977 his death occurred nevertheless.

A Tribute to Mike Blomquist

To the students of Roosevelt High School:

As the family of Mike Blomquist, we would like to thank all of the students at Roosevelt High School who paid their respects to Mike at his visitation and funeral. It was comforting to us to know that he had so many friends. We would also like to thank the many people who tried to help Mike in the past five months.

The question that naturally arises after an incident such as this is why did it happen. Our family has been struggling with this question since February 10, the day Mike took his life. Why does a young man who has so many people who love him become so depressed that he can no longer face life?

In pondering this question, we have been unable to find one definitive reason or cause. As with many teenagers, Mike faced many personal adjustment problems, but he seemed to handle these quite well until this past summer. When faced with several major emotional problems at this time, he resorted to using hard drugs. Because of strong peer pressure and because he was not emotionally strong, Mike had apparently been drinking beer and had been smoking marijuana for several years. The family, as is often the case, was unaware of this until last summer when he began using Angel Dust. From this point until his death, a period of approximately six months, Mike's life was a living hell.

We are not saying that drug usage alone killed Mike, but the drug usage clouded his mind and caused him to be unable to deal with the problems he faced.

As the minister at Mike's funeral said, the 17 year old of today faces more pressures than the 17 year old of any generation. We agree with this, but what frightens us is that so many teenagers today are living as Mike lived, taking drugs to try to escape from reality.

We tried to impress on Mike that as difficult as reality might be at times, he had to learn to face his problems and deal with them. By using drugs, he was not facing his problems but rather avoiding them, allowing them to build up until there were so many and so complex that the only solution seemed total escape.

Though there is nothing we can say or do at this point to change what happened to Mike, we would only hope that you students will learn from this tragic experience. We would hope that you would examine your own lifestyle to see in which direction you are headed. Frightening to us are the numbers of teenagers we have heard in recent months who say, "I only drink beer and smoke pot occasionally. I'm not dependent. I can handle it."

This is what Mike said, and now he is gone.

Though we are not drug counselors and do not want to preach to you, we would like to spare you and your families the anguish and pain that we are now suffering. To do this we would like to offer the following suggestions:

—If you have not started to use drugs—don't start. Learn to handle frustration and disappointment within your own emotional systems without the aid of drugs.

—If you are using drugs on a mild basis, stop now before you become totally dependent. Even at this stage the withdrawal will be difficult, but you can accomplish it.

—If you know that you are totally dependent, seek the aid of some helping person. Go to your parents, a teacher, a counselor, or anyone who will listen, and try to get into a treatment center such as St. Mary's. Remember, before anyone can help you, you've got to want to help yourself. Many people tried to help Mike. He had been developing a behavior pattern of drug usage over a three year period; to change behavior that has developed over that period of time takes more than ten days. It may take three months, six months or even longer, but the rewards can be great—your life.

—To those people who don't use drugs but who have friends who do, you have a moral responsibility to try to help them stop using. We realize the difficulty in doing this, but in intervening, you may be saving a life.

Though we deeply appreciate all the cards and letters and expressions of sorrow that have been extended to us, we feel that the finest tribute you could pay to Mike is to try to help eliminate drug usage among the students at Roosevelt. We know that the drug problem exists at every high school among teenagers in every community in the United States, but if Mike's needless death can touch and positively change one life at Roosevelt High School, we will feel that perhaps he did not die in vain.

Drugs destroyed Mike; please don't let them destroy you.

The family of Mike Blomquist

We are indebted to the Blomquist family for giving us permission to reprint this article.

APPENDIX II

Sample curriculum for unit on Living Preventively, Unit XVII of Dimensions of Loss and Death Education: A Resource and Curriculum Guide, by Patricia Weller Zalaznik, published by Edu-Pac Publishing Co., Minneapolis, Minnesota (1979); All rights reserved. *

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XVII. LIVING PREVENTIVELY

Objective: Awareness of major causes of death and behaviors that can prevent or minimize chances of death.

Content	Cognitive Learning Experiences	Affective Learning Experiences
1. Among major causes of death are heart disease, cancer, strokes, accidents and suicide.	1. Look up current statistics and gather current reference materials on major causes of death.	1. As a group brainstorm all of the ways in which people could change their behavior to prevent death (e. g., quit smoking, have physical examinations). See resource section. (WB-64)
2. Behavior and death.	2. Construct a list of risk-taking activities in which members of class are involved. This could include smoking, use of chemicals, sky-diving and so forth. Rank activities as being high, medium or low risk. (WB-64)	2. Individually and/or in pairs go over list of risk-taking activities to see behaviors in which person is involved. Answer question. "In view of the idea of living preventively, are there changes I may want to make? If so, what?" (WB-64)
3. Stress: Human beings live in stress, both internal and external. Part of stress is healthy and develops motivation. Too much stress may have harmful effects.	3. Examine definitions of stress and come to one common definition such as, "Stress is a non-specific response of the body to external demand. It is usually expressed by fight, flight, or freeze." Take Dr. Holmes' stress scale "The Social Readjustment Rating Scale" and demine personal level of stress. Note Holmes' relationship of stress to illness. Identify other types of stress in addition to those listed in scale. Consider ranking these. Read references on stress and levels of stress. Discover positive ways to cope with it. Share with class.	3. **Personal**: Write a one-to-two page essay on "Stress in My Life." Some possible themes might be: a. Stress in the family b. Stress in school c. Stress in decisions to be made about the future d. Stress experienced in social relationships (such as peer pressure to drink or take drugs). (WB-65) Small Group: a. Share ideas about personal stress b. share ideas on how to cope with stress c. Share ideas on where to get help in resolution of stressful circumstances (e. g., Alateen, Emotions Anonymous).

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	Examine problems of stress in groups such as minorities, poverty-level populations, elderly, in certain jobs, situations, and so forth.	**Class:** Identify all kinds of stress we may experience. List possible solutions. Make personal posters such as TCOR (i. e., "Take Care Of Robert") or the Alcoholics Anonymous Serenity Prayer: "God grant me the serenity to accept things I cannot change, the courage to change the things I can, and the wisdom to know the difference."
4. Crisis.	4. Read references on crisis and crisis intervention. Arrange for speakers on preventive measures such as coronary-pulmonary resuscitation. Make posters for heavy-traffic areas in school to publicize how people can get help such as hot lines, hospital, AA, rape counseling center, suicide prevention centers, legal aid society, etc. See resource section. (WB-66)	4. **Personal:** Write a 1-2 page essay on "A Crisis in My Life." For example: "When my 18-year-old cousin died," "When I almost lost my ability to walk as a result of a car accident," "When X committed suicide and left me feeling abandoned." Include in this essay a description of the event, where you are involved in the relationship, and your various feelings about the situation. It is possible to use fictitious names and places. All papers will be treated with confidentiality. (WB-67) **Small Group:** Identify a crisis or crises. Use local paper to help identify them. Circle with marking pen and share. After becoming conscious of variety of crises, brainstorm resources in resolving problems. Have guest speaker on coping with crisis. Use reputable experts. **Class:** Select a crisis which group would consider appropriate action to help. See how group might want to help.

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UNIT XVII

CRISIS RESOURCES

1. Alanon
2. Alateen
3. Alcoholic's Anonymous
4. Cancer Society, information service
5. Centers for Elderly
6. County welfare agencies
7. Emotions Anonymous
8. Gamblers Anonymous
9. Groups for battered wives
10. Growth awareness and support programs
11. Narcanon
12. Organizations for homosexuals
13. Organizations to service pregnant teenagers, birthright
14. Overeaters Anonymous
15. Parents Without Partners
16. Reach to Recovery (after mastectomies)
17. Religious organizations such as Catholic, Jewish, Lutheran Social Service
18. United Ostomy (colostomies, ileostomies)

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REACTION SHEET FOR

_______________ UNIT ON

DIMENSIONS OF LOSS AND DEATH

Name ______________________

Period ____

Date ______________

MAJOR FACTS:	MY PERSONAL FEELINGS:

QUESTIONS I WANT ANSWERED:

1.

2.

3.

4.

ADDENDUM TO PREPARED TESTIMONY

The State of Florida passed legislation in 1983 that mandates a Life Management Skills course as a prerequisite for high school graduation in Florida.

In 1984, State Senator Bill Grant expressed concern about increasing numbers of suicides among adolescents in Florida. Working closely with home economists and members of the Florida unit of the American Home Economics Association, the Senator and his colleagues in the legislature passed the Florida Youth Development and Suicide Prevention Act. That law establishes a state wide program to promote positive emotional development of youths and to prevent suicide by youths through coordinated educational efforts at the state and local levels in cooperation with community suicide prevention and crises center agencies. Under this legislation, "positive emotional development" was added as a requirement to the previously-mandated course in Life Management Skills.

For the past year, home economist Betty Lou Joanos, of Florida State University in Tallahassee, has been active as a member of a state wide task force to develop curriculum for teenage suicide prevention. A Guide for Trainers of Youth Suicide Awareness currently is in its final stage of completion. The curriculum includes separate guides for the average student, the academically disadvantaged student, the academically advantaged student and the adult student. Federal seed money for Consumer and Homemaker Education (home economics) under the Carl D. Perkins Vocational Education Act of 1984 (P.L. 98-524) has played an important role in the research and development of this course.

Attachments (2)

MANDATED CURRICULUM FLORIDA 1985

CURRICULUM FRAMEWORK PROGRAM AREA: Home Economics
FLORIDA DEPARTMENT OF EDUCATION EFFECTIVE DATE: July, 1985
COURSE TITLE: Life Management Skills
CODE NUMBER: Secondary 8500330 Postsecondary ____
Florida CIP CN20.010600

SECONDARY SCHOOL CREDITS .5 COLLEGE CREDITS ____ POSTSECONDARY ADULT VOCATIONAL CREDITS ____

APPLICABLE LEVEL(S): ____ 7-9 X 9-12 ____ Postsecondary Adult Vocational
____ Postsecondary Vocational X Other 21

CERTIFICATION COVERAGE: VOC HME EC 4

I. MAJOR CONCEPTS/CONTENT: The purpose of this course is to provide students with essential life management skills to enhance the quality of personal and family life.

The content includes, but is not limited to, positive emotional, social, physical, and intellectual development of self and others; nutrition; consumer education and resource management; substance abuse; hazards of smoking; breast self-examination and breast cancer detection; cardiopulmonary resuscitation; roles and responsibilities of families and family members; decision-making and coping skills; and public and private agencies and services affecting individuals and families.

II. LABORATORY ACTIVITIES: Instruction and learning activities are provided in a laboratory setting using hands-on experiences with the tools and materials appropriate to the course content and in accordance with current practices. Activities provide instruction in the use of equipment including large kitchen equipment, small appliances, laundry equipment, infant child care equipment, CPR manakins, audio-visual equipment and materials, home technology equipment and softwear, general classroom equipment and storage equipment.

III. SPECIAL NOTE: Future Homemakers of America/Home Economics Related Occupations is the appropriate vocational student organization for providing leadership training experiences and for reinforcing specific vocational skills. When provided, these activities are considered an integral part of this instructional course.

The concept of management is an integral part of the course and should be reflected in the facility, equipment, instructional materials and learning experiences.

The typical length of this course for the average achieving student is 75 hours.

IV. INTENDED OUTCOMES: After successfully completing this course, the student will be able to:

01. Promote positive emotional, social, physical, and intellectual development of self and others.
02. Determine the role of the family in personal development.
03. Apply principles of nutrition to food decisions.
04. Demonstrate responsible consumer decisions and management techniques.
05. Make responsible decisions regarding substance use (alcohol, drugs, tobacco).
06. Perform cardiopulmonary resuscitation.
07. Receive information and instruction on breast cancer, including self-examination.
08. Receive information and instruction on suicide prevention.
09. Demonstrate leadership and organizational skills.

STUDENT PERFORMANCE STANDARDS

LIFE MANAGEMENT SKILLS

01.0 PROMOTE POSITIVE EMOTIONAL, SOCIAL, PHYSICAL AND INTELLECTUAL DEVELOPMENT OF SELF AND OTHERS--The student will be able to:

01.01 Establish goals and priorities.
01.02 Use decision-making processes.
01.03 Determine the components of positive self-esteem.
01.04 Identify techniques to strengthen and reinforce positive self-esteem.
01.05 Identify characteristics of a responsible individual.
01.06 Identify ways for coping with personal stress and crises.
01.07 Plan effective communications with family and peers.

02.0 DETERMINE THE ROLE OF THE FAMILY IN PERSONAL DEVELOPMENT--The student will be able to:

02.01 Name the stages in the family life cycle.
02.02 Relate the stages of the family life cycle to development of the individual.
02.03 Identify responsibilities of a family member.
02.04 Identify ways for coping with family stress and crises.
02.05 Identify public and private agencies addressing family concerns.
02.06 Define the dual role and responsibilities of homemaker/wage earner.
02.07 Identify trends that may affect personal and family goals.

03.0 APPLY PRINCIPLES OF NUTRITION TO FOOD DECISIONS--The student will be able to:

03.01 Determine nutritional values of foods.
03.02 Plan nutritionally balanced meals.
03.03 Prepare and serve nutritionally balanced meals.
03.04 Identify the interrelationship of nutrition and positive emotional development.
03.05 Evaluate nutrition information.

04.0 DEMONSTRATE RESPONSIBLE CONSUMER DECISIONS AND MANAGEMENT TECHNIQUES--The student will be able to:

04.01 Identify consumer rights and responsibilities.
04.02 Distinguish between needs and wants.
04.03 Apply budgeting principles.
04.04 Recognize that credit costs.
04.05 Identify the services of financial institutions.
04.06 Evaluate effects of advertising on consumer decisions.

05.0 MAKE RESPONSIBLE DECISIONS REGARDING SUBSTANCE USE (ALCOHOL, DRUGS TOBACCO)--The student will be able to:

05.01 Analyze reasons for substance use and abuse.
05.02 Evaluate the effects, substance use and abuse can have on personal and family life.
05.03 Evaluate the legal ramifications of substance use and abuse.

06.0 PERFORM CARDIOPULMONARY RESUSCITATION--The student will be able to:

06.01 Perform one-rescuer cardiopulmonary resuscitation.
06.02 Perform emergency relief on a person with an obstructed airway.

07.0 RECEIVE INFORMATION AND INSTRUCTION ON BREAST CANCER, INCLUDING SELF-EXAMINATION--The student will be able to:

07.01 List the symptoms of breast cancer.
07.02 Apply self-examination.
07.03 Identify community and private resources that can provide information and services.

08.0 DEMONSTRATE LEADERSHIP AND ORGANIZATIONAL SKILLS--The student will be able to:

08.01 Identify professional and youth organizations.
08.02 Identify purposes and functions of professional and youth organizations.
08.03 Identify roles and responsibilities of members.

LIFE MANAGEMENT SKILLS - Continued

08.0 DEMONSTRATE LEADERSHIP AND ORGANIZATIONAL SKILLS - Continued

08.04 Work cooperatively as a group member to achieve organizational goals.
08.05 Demonstrate confidence in leadership roles and organizational responsibilities.
08.06 Demonstrate commitment to achieve organizational goals.
08.07 Develop a personal growth project.

Tallahassee Democrat
Fri. Oct. 18, 1985/3B.

Officials honor Pensacola teen-ager credited with preventing man's suicide

Associated Press

PENSACOLA – A 16-year-old summer employee of Florida's social-services agency has been credited with preventing the suicide of a men who had swallowed a bottle of sleeping pills.

The youngster saved the man by getting his location and keeping him awake by talking to him on the telephone, officials said.

Rhonda Johnson, a Pensacola High School student, received a pleque Tuesday from Dick Grimm, district director of the Department of Health and Rehabilitative Services, during a meeting of the Escambia County School Board.

Hiring teen-agers "works both ways," Grimm said. "In this case, we got some very fine help from Rhonda, help that in fact saved someone's life. Very few people can tell their grandchildren that they saved someone's life."

Rhonda, who plans to study advertising at Florida State University after she finishes high school, had taken a clerk-typist job with HRS to make some money this summer.

She inadvertantly was thrust into the role of crisis counselor.

When the distraught man called Aug. 14, Rhonda was alone in the Drug Abuse and Mental Health Program office, which functions as a referral agency rather than a crisis center. Regular staffers were attending a meeting elsewhere in the Chappie James State Office Building.

Rhonda kept the man, in his late 40s, talking until he was calm enough to tell her what he had taken and that he was in a phone booth in the Scenic Heights area of Pensacola.

"I just was babbling about anything I could think of," she said.

She started talking about her teen-age brother. That helped because the man then wanted to talk about an argument he had with his own teen-age son and his wife, which had prompted him to try to take his life.

Her impromptu conseling kept the drugged man awake until Ellie Weatherspoon, the HRS program supervisor, returned and took over.

"She kept her wits about her all the time," Weatherspoon said.

While Weetherspoon tried to keep the man on the line, Rhonda called Escambia County Emergency Medical Services, which dispatched an ambulance.

They had kept the man awake nearly until the ambulance arrived. The ambulance crew found him unconscious next to the phone booth. He was taken to a hospital where he was treated.

"Rhonda said she recalled some of the instructions from her Life Management course (in high school)," Weatherspoon said. "She exercised tremendous skill for her age."

Weatherspoon said Rhonda used some of the same techniques a professionally trained counselor would have employed to establish rapport and maintain contact with the victim.

"This really proves the value of providing summer employment for youth," Grimm said. "It gives them a look at the helping professions and a taste of the working world before they make up their minds on a career."